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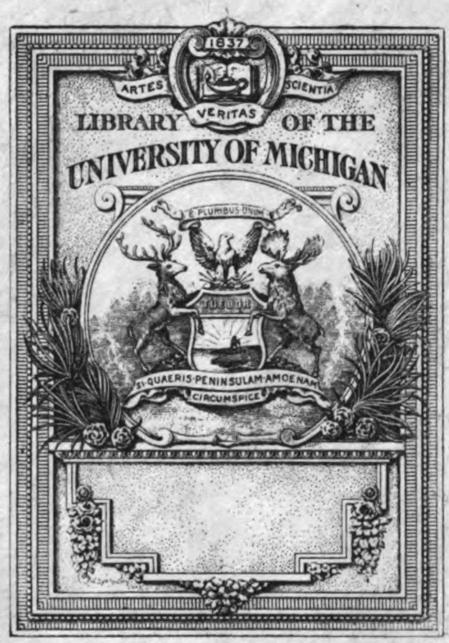

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NOTES AND COMMENTS.

Lord Lister and the City.

THE presentation of the Freedom of the City of London to Lord Lister last Friday cannot but give rise to some reflections on the position which the representatives of medical science hold in the estimation of their contemporaries. Lord Lister is well over eighty years of age; for twenty-five years he has been recognised all over the civilised world as the greatest benefactor to humanity that this age, or perhaps any age, has produced; he has been honoured in every civilised country by the conferment of such dignities as each could bestow; moreover his eminence is only surpassed by his modesty, his disinterestedness, and his sterling honesty. It is no exaggeration to say that for a quarter of a century Lord Lister has been the worthiest and most distinguished British subject in the kingdom, and he may fairly be claimed as a Londoner to boot. In his brief and modest speech on receiving the freedom Lord Lister spoke of it as "the highest civic honour in the world," and though medical men are duly grateful to the City for having bestowed it on Lord Lister, they cannot but wonder how it is that it has so long been withheld, and whether it would have been granted at all but for the fact that a medical man who believes in his own profession is Senior Sheriff for the year. Every year the freedom of the City is conferred on some Royal person, often from some quite second-rate country and from the point of view of humanity quite undistinguished, or on some victorious admiral or general who has doubtless rendered great service to his country, but whose achievement will frequently not be deemed of sufficient magnitude to require mention in a history-book of a hundred years hence, or on some person whose exploits are making good "copy" for the newspapers of the moment. On such occasions the streets are lined with troops, flags and banners adorn every building on the route, and all the most distinguished officers of the State are assembled to welcome the hero.

Science and British Citizenship.

ON Friday a bare handful of gentlemen, mostly medical men, assembled in the Guildhall to receive Lord Lister, there were no soldiers, and we are bound to believe that not ten persons in the City knew that any unusual event was toward. Most of the newspapers considered half a column on an inside sheet sufficient to record the event. Thus shall be done to the man whom the world delighteth to honour! There is no gainsaying the fact that in America and on the Continent Lister is a name to conjure with, and we believe if a vote were taken as to who was the greatest living Englishman, he would be easily first; yet in his own country in his old age he is fobbed off with semi-private presentation of the Freedom of the City without a cheer from his fellow citizens in the streets. It is true that Lister is the first and only medical man on whom a peerage has been conferred, but that peerage is only a barony, whilst a politician, soldier, or wealthy brewer will often despise anything below a Viscountcy or Earldom; and the bare idea of a public pension or money grant, such as the politician or soldier receives, and the brewer does not need, would raise a smile. But perhaps the truest honour and highest reward is for a man to be loved, respected and unenvied by those of his own calling, and Lord Lister has passed through the storm of controversy to the haven of honoured old age, enshrined in the hearts of medical men as their worthiest and noblest comrade. Perhaps for that reason they would wish all the more for his name to be a household word and his portrait a household possession throughout the land.

The Evans Brothers.

THE carpenter cancer-"curing" brothers at Cardigan continue to attract an enormous number of patients, and from accounts it appears that the lodgings in the town are full of sufferers seeking the aid that has been so widely advertised. Indeed, in a letter which would be comic but for the underlying pathos of the circumstances, the Evans have addressed the public through the Press asking patients not to come without special appointment, as they have already more work than they can adequately cope with. They say, "We find it impossible to give proper attention to the large number under our care. . . . This is a great disadvantage to us, and seriously injurious to those who are ill." One special correspondent reports that probably over five hundred patients are already being dealt with, so that we may safely conclude that a pretty good thing is being made out of this "secret." It seems that cancer is not the only disease to which the method is applied, for not only are scirrhous carcinomas of the breast and epitheliomas of the face reported,

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but lupus, necrosis of the nasal bones, and (save the mark!) polypus of the nose are specifically noted. The treatment, however, seems to be the same for all. Some of the "secret" fluid is painted on to the diseased part, an application of fresh leaves applied, and a dressing placed over all. These wonder-working brethren describe themselves as "herbalists," but it would not be a very hazardous guess to assert that this mysterious fluid contains arsenic as a prominent ingredient. The arsenical treatment of external cancer is always cropping up in one form or another, and the improvement which follows the separation of the slough produced by the caustic has been the stock-in-trade of cancer-quacks innumerable. From the published accounts it seems that the patients are not so universally satisfied as was at one time given out. That is as might be expected; the denouement in these matters is seldom as sudden as in a play.

Doctors as Dictators.

A curious but not unsympathetic article on "Doctors as Dictators" appeared in *The New Age*, a Socialist organ, last week. Indeed we may congratulate the writer on possessing a considerable amount of acumen and some working knowledge of the conditions of medical practice. It may not be flattering to us to be told that "essentially the doctor nowadays is an upper servant," but as the writer wishes to deliver us from this thraldom he at least deserves the gratitude of those who groan in the bondage of their masters. But what we are glad to learn is that Socialists have no quarrel with medicine or medical men, but rather that they acknowledge the benefits of medical science and would like to promote them. At the same time they consider that scientific merit and personal worth are only factors in a practitioner's success, and that his advice has to be adapted to the whim and social position of the patient. The writer in *The New Age* considers that the cry of "Doctors as Dictators" is a bogie, and that on the contrary the doctor is very much dictated to by the State and by his circumstances and patients. We may say with little hesitation that if the Socialists would release the profession from the painful necessity of having to do as they are bid, and would allow them to act on the scientific ideal in all cases, they would achieve immense popularity with the profession, but till old things are passed away and a new age is firmly established, we fear that men will still have their weaknesses and failings, and these will continue to cause the doctor frequently to subordinate his theoretical ideal to the practicabilities of the situation.

Livingstone College.

We publish in another column a letter from Dr. Charles F. Harford, Principal of Livingstone Medical College, commenting on some remarks in The Medical Press and Circular of June 19th, with regard to that institution. While cordially appreciating the tone of Dr. Harford's letter, and sympathetically entering into the difficulties of the position, we still feel inclined to repeat what we then said, namely, "That we find it difficult to recommend a system of unqualified practice among natives which we would condemn if pursued at home, and we notice from the report that some of the Livingstone alumni seem to practise quite extensively." We gladly accept the statement that students at the College sign a declaration that they will not represent themselves as medical missionaries or assume the position of qualified medical men; that is certainly as it should be, but does the child of nature draw the line very accurately between registered and unregistered practitioners? The only logical solution of the difficulty would be for all missionaries to be medical men, or to act only as assistants to a medical man; but presumably that is an ideal which the Church Missionary Society cannot practically fulfil at the moment. Still it is the one that should be aimed at, and if Livingstone College marks a transition in that direction, we should not be so churlish as not to wish it God-speed.

LEADING ARTICLES.

LORD LISTER AND THE FREEDOM OF THE CITY OF LONDON.

On Friday last, June 28th, Lord Lister was formally presented with the Freedom of the City of London in the ancient and historic Guildhall. The auspicious event took place, with appropriate ceremony, in the midst of an assemblage of distinguished men. The scroll of the freedom was enclosed in a gold casket of elaborate design, surmounted by a figure of Hygeia, and having at opposite ends of the base two figures, one representing London offering the scroll of freedom, and the other symbolising medical science holding out the torch of Fame. In making the presentation the City Chamberlain, Sir Joseph Dimsdale, remarked that Lord Lister, by blending the antiseptic treatment with modern surgery, had made possible what previously seemed impossible. In acknowledging the presentation Lord Lister said simply that the work in which it had been his great privilege to be engaged had brought its own reward. At the end of a brief speech he made a pathetic allusion to the consideration of the Court which permitted him to attend at his own convenience. Had it been otherwise the state of his health would have prevented his personal acceptance of their gift in that historic building. Of all the great events that have been dignified in this centre of English history it may be questioned if any more worthy of civic and national honour has ever been celebrated therein. Unquestionably Lister's name will be for ever one of the greatest and most revered in the world of medicine. The Corporation of London may be congratulated upon their action in conferring the highest dignity within their power upon the man who has probably done more than any single man for the advance of medical science and the relief of suffering humanity.

DEATHS UNDER ANÆSTHETICS.

The question of deaths under anæsthetics has vexed the minds of medical men ever since the introduction of the great boon of general anæsthesia. As years go by and experience accumulates, the conclusion appears to be more and more inevitable that there must always be an unavoidable margin of accompanying fatalities. True, some drugs used for the purpose are less dangerous than others, but, unfortunately, the safer ones are otherwise unsuitable for any but minor operations, while not a single one is absolutely safe. Yet it would be contrary to the spirit that animates the student of modern scientific medicine were he to accept the position as one incapable of further improvement. On the contrary, he is bringing to bear upon the problem every ray of light that may be obtained from the chemist, the physiologist, the pathologist, the surgeon, the anæsthetist, or from any other available quarter. Recently the introduction of spinal anæsthesia has opened up a novel departure in this highly technical branch of work, and it may even be that the final solution will be found somewhere in that direction. Meanwhile it seems not altogether impossible, in the light of recent enquiries, that some additions to our knowledge of fatal anæsthesia may be gathered from a systematic examination of all cases on certain clear and well-defined lines. The Coroner of the City of London, Dr. F. J. Waldo, has recently paid a great deal of attention to enquiries of this kind, and has gathered a mass of information that cannot fail to be of interest, and may possibly prove of real value. By drawing up exhaustive tables of the proportion of deaths to administrations under various anæsthetics, it is possible to compare the accompanying conditions. It seems to be a fact that with a given anæsthetic there are proportionately more deaths in one institution than in another. By investigation there is an obvious possibility that contributory causes may be detected in the peculiar conditions of the administrations where the greater fatality exists. One particular point worthy of careful enquiry is the exact chemical composition and source of origin, as well as cost, of each anæsthetic drug or combination of drugs. For some reason or other this aspect of anæsthetics has never been as fully dealt with as its importance certainly appears to demand. The matter, of course, touches delicate ground and would have to be dealt with tactfully. If handled without due caution, a serious injury might inadvertently be inflicted upon this or that medical charity. We should decline to believe, however, that such a suggestion would for a moment prevent any great modern hospital from lending its utmost aid to any enquiry that might help to lessen in any way the sum total of deaths under anæsthesia. There is no apparent reason, for that matter, why all enquiries should not be strictly impersonal. The statistics could be drawn up readily enough without giving the name of any institution, by resorting to the simple artifice of reference numbers. So important is an investigation of the sort to the welfare of the community that we would suggest a Governmental enquiry by a competent scientific body as a proposition requiring little argument in favour of its desirability. To avoid so plain a duty in deference to timid or hostile interests would be to reverse the outspoken and fearless candour which is one of the chief characteristics, as it is the foundation, of progressive medical science.

CURRENT TOPICS.

The Long Hours of Railwaymen.

It is an old story that many railway accidents are directly due to the fatigue of over-worked servants. This fact has been once again emphasised in a White Paper issued last week by the Board of Trade. Since the year 1900 there were thirty-four such accidents, five of them being in Ireland. A particularly bad record comes from Goole, where four accidents took place, involving the death of one railway servant and injury to three others. In the first instance a shunter was killed after working 14½ hours continuously. In the three injuries the men had been on duty 13½, 14¼ and 16 hours respectively. A fireman killed at Clapham Junction had worked 17½ hours. The record number of hours appears to have been that of a platelayer killed at Nottingham, who had worked 23¼ out of 30¼ hours, when he was run over and killed. A collision between two passenger trains at Broad Street, London, in 1904, was due to the mistake of a signalman who had been on duty 12 hours daily for the three preceding days. The whole matter is one that urgently demands legislative action in the interests both of the railwaymen and of the travelling public. As a plain statement of fact the economic loss must necessarily fall, in the long run, upon the community from whom the railway companies draw their revenues, including that portion which has to be paid away as compensation for accidents and fatalities. Clearly the public that thus pays the piper should be entitled to a voice in the conditions of employment that have been shown to be fraught with such disastrous consequences.

The Prime Minister and the Royal Commission on Cancer.

Medical officialism has again prevailed against medical opinion. In the House of Commons last week, the Prime Minister in reply to a question asking for the appointment of a Royal Commission on cancer, said "he had made inquiries of the authorities who were best qualified to express an opinion, and he was advised that it would not be expedient at present to recommend the appointment of a Royal Commission to inquire into the causes of the disease . . . and he was advised that much remained to be done before any facts could be brought before a Royal Commission with any likelihood of their making such an inquiry fruitful for the public advantage." In formulating this reply reference was made to the Imperial Cancer Research Fund ; it is therefore not difficult to infer that the "authorities who were best qualified to express an opinion," implied the Executive of this Fund, and that the strange opinion expressed by the Prime Minister on this matter was due to them. The opinion certainly was an extraordinary one, on the face of the evidence which has guided the profession generally in arriving at the conviction that such an inquiry would, as the Medical Press and Circular stated last week, prove "of enormous educative value." The force of circumstances, however, having placed the Imperial Cancer Research Fund in the position of arbiter, as between the profession, the public, and the Government of the day, it is only due to those who subscribe to the Fund to be informed upon what grounds the Executive of the Fund have advised the present Government that an inquiry is unnecessary. Doubtless, having practically been appointed arbiters, the Fund are waiting to substantiate their position as such, and this view of the case is more than likely to be the correct one, seeing that the Fund have been singularly neglectful in showing what they have done in advancing our knowledge of the disease. The fitful outbursts of cancer "booms" in the lay press are simply due to the lordly scientific silence which the Fund persists in observing whenever any matters regarding the disease obviously demand official refutation. Lay editors would hardly dare to continue to publish "facts" about cancer after having been officially informed that such "facts" were merely impossible creations, and not worthy of credence. Before long, however, public opinion will demand a Cancer Inquiry; already the lay press are beginning to direct attention to its necessity, and then "those best qualified to express an opinion" against it will find themselves powerless to resist the demand. Thus will Nemesis fall upon them for failing to recognise in the past that they have a duty to discharge towards the public in correcting statements in the Press which to the medical man are obviously inaccurate.

The Teaching of Hygiene in Elementary Schools.

The reply of Mr. McKenna to the deputation which waited on him recently in reference to the above subject was, like replies given on other occasions by his predecessors, sympathetic but noncommittal. The deputation urged the importance of giving instruction to children in the subjects of hygiene and temperance, of training teachers in these subjects, and of their being reported on by H.M. Inspectors of Schools. Mr. McKenna declared himself in full agreement with the desires of the deputation, but he confessed himself unable at present to find means of carrying them into effect. He hoped, however, that after hearing the views to be put forward at the International Conference in August, he might be in a position to suggest a solution of the difficulties. We confess we cannot see that the obstacles are so great as they appear to the official mind. It is true that the teachers must themselves be instructed before they begin to teach the children, but this could easily be done in a few carefully planned holiday courses. Within the course of a few years, the Department of Technical Instruction in Ireland has found it possible to train a sufficient staff of teachers in experimental and natural science, not for the primary but for the secondary schools of Ireland. The task facing Mr. McKenna is by no means more difficult. His complaints, too, as to the difficulty of compiling a syllabus for instruction in hygiene seems like making a mountain of a mole-hill. It was unfortunate that Mr. McKenna should have been ruffled by what he considered the "peremptory" manner adopted by some of the members of the deputation.

The Housing Problem in Ireland.

Of the many problems facing the sanitary reformer in our cities and towns, one of the most urgent is that of providing proper housing for the poorer classes. It stands, indeed, in the forefront of many questions intimately dependent on it. In the struggle against tuberculosis, in the battle against intemperance, in the extermination of all filth diseases, the providing of proper housing is all-important. In dealing with the question, economic as well as sanitary considerations have weight, and some method must be found by which houses in large numbers can be supplied without an economic loss. In the discussion on the subject at the meeting of the Royal Sanitary Institute in Dublin last week, two ways of finding a solution were put forward. Either large blocks must be erected in the heart of great cities, or improved communication with the suburbs must be established, so as to permit of cottages being built on cheaper sites. The latter plan has many points in its favour. It is more economical, in that land can be bought at cheaper rates, and it has the further advantage that the cottages can be placed in healthy surroundings where their inhabitants can have the benefit of fresh air and sunlight. It has the drawback that it takes workmen to a distance from their work and puts them to the expense of a tram or rail journey morning and evening. With improved means of conveyance, however, it is to be hoped that the chief of these inconveniences may disappear.

The King Edward Fund Bill.

On Monday, July 2nd, the King Edward Hospital Fund Bill passed the Commons.. The amendment brought forward by Dr. Rutherford in favour of representative control was ultimately withdrawn under strong pressure from high quarters on both sides of the House. As a matter of fact, the original Bill has been considerably altered since attention was first publicly drawn by the medical journals to its autocratic constitution. The Prime Minister reminded the House that the Council of the Fund included the Lords-Lieutenant of London and Middlesex, the Bishops of London, Southwark, Westminster, the President of the Free Churches, the Chief Rabbi, Chairman L.C.C., Governor of the Bank of England, and the Presidents of the Royal College of Physicians and Surgeons. It will be noted that the main mass of the medical profession, the hospitals and the public are unrepresented. Above all, the small hospitals, who already complain of injustice at the hands of the Funds, are without a single representative. Under these circumstances the Fund can hardly wonder if it has occasionally to face the fires of searching criticism.

The Housing Reform Congress.

For the first time in history the International Congress on Housing Reform will meet in the United Kingdom. It is to be hoped that the great gathering to be held in London early in August will do something to educate the nation generally upon a matter so vital to their well-being. It seems probable that in no country in the world does the jerry-builder flourish with greater impunity than in our own long-suffering realm. The absence of stringent building acts from our Statute book constitutes a standing reproach to a nation that prides itself on its practical handling of public health matters. Over the whole face of the land houses are springing up like multitudinous mushrooms in the suburbs of towns, both small and great. A brief inspection of these speculative dwellings will reveal the fact that they are more or less riddled with appalling structural and sanitary defects. Of late it has been the fashion to raise sensational outcries on the question of impure food. Clearly, however, the provision of sound and sanitary housing is of no less importance to the sturdiness of our race. Let us hope that the forthcoming Conference will teach the man in the street what the law should empower him to demand from his landlord.

Bacteria and the Tram-ticket.

The public mind is being agitated at the moment about the possible dangers to health incurred by accepting a tram-ticket from the conductor of the car. Indeed, a question on the subject was recently put to the Home Secretary. An ingenious French bacteriologist lately examined a number of these tickets and found them to contain germs innumerable and those of the deadliest character. Far be it from us to decry scientific research or bacteriological methods, but let us at least remember we live in a practical world. Desirable as the sterilisation of tram-tickets may be, it would be quite useless unless the conductor dealt them out with aseptic hands, and however aseptic the conductor's hands might be when he started out in the morning, they would certainly be freely infected by the first fare he received from a passenger. In a Utopian tram it might be possible for a conductor to wear a sterilised overall and to serve out sterilised tickets with sterilised hands, but in order to complete the requirements of hygiene he would have to deal only with sterilised passengers paying sterilised fares. At present the chief danger to be apprehended from the tram-ticket is the creation of hysteria in those who have yet to learn that the doctrine of the immanence of bacterium. With the 'bus-ticket there need be no difficulty as there is no obligation on the passenger to preserve it, and it may be thrown away as soon as it has been handed to him. The 'bus companies cannot demand that a ticket shall be produced for inspection, although they would fain have people believe they can. Let us, however, take our tram-tickets with thankfulness, asking no questions for conscience sake.

PERSONAL.

The following medical men had honours conferred upon them on the occasion of the official celebration of the King's Birthday last week:—

To be Knight Bachelors—
- Horace Rosborough Swanzy, Esq., M.D., President of the Royal College of Surgeons of Ireland.
- Mr. Alderman Thomas Boor Crosby, M.D., Sheriff of the City of London.

To be K.C.B. (Military Division)—
- Inspector-General Herbert Mackay Ellis, R.N., Honorary Physician to the King.

To be C.B. (Military Division)—
- Deputy Inspector-General Thomas Desmond Gimlette, R.N.
- Surgeon-General Francis Wollaston Trevor, Principal Medical Officer, Western Command, India.
- Colonel George Deane Bourke, Administrative Medical Officer, Southern Command.

To be Hon. C.I.E.—
- Dr. Jean Etienne Justin Schneider, Principal Doctor of the First Class, French Army, late Chief Physician to the Shah.

To be C.I.E.—
- Surgeon Lieut.-Colonel Warren Roland Crooke-Lawless, M.D., Coldstream Guards, Surgeon to His Excellency the Viceroy of India.

To receive the Kaisar-i-Hind Medal—
- Rai Bahadur A. Mitra, L.R.C.P. and S. Edin., Chief Medical Officer, Kashmir.

To be G.C.M.G.—
- Sir William MacGregor, M.D., K.C.M.G., C.B., Governor and Commander-in-Chief, Newfoundland.

The King has also specially appointed to the Order of the Bath the following veterans, who served in the Mutiny:—Surgeon-General Thomas Tarrant, Honorary Physician to the King; Deputy Surgeon-General Edward Malcolm Sinclair, late Army Medical Staff; Deputy Surgeon-General Alfred Eteson, late Indian Medical Service.

We have to congratulate Sir James Blyth, who has done so much to help forward the investigation of tuberculosis, on his being raised to the Peerage.

Dr. D. C. Watson was elected Assistant Physician, and Mr. W. J. Stewart, Assistant Surgeon, to the Edinburgh Royal Infirmary, on June 24th.

Dr. J. Odery Symes has been unanimously elected Physician to the Bristol General Hospital to fill the vacancy created by the death of Dr. Markham Skerritt. Dr. Carey P. Coombes has been elected Assistant Physician to the same institution.

Dr. R. H. Kennan, Senior Medical Officer of Sierra Leone, is acting as Principal Medical Officer of that Colony during the absence on leave of Dr. R. M. Forde, who has arrived in England.

Professor Osler will present the prizes to the successful students at the London School of Medicine for Women, at 4 p.m. to.morrow. The gathering will be held at the Royal Free Hospital, with Mrs. Garrett Anderson in the chair.

Mrs. Russell Sage has contributed £60,000 towards the foundation of an Institute of Pathology in connettion with the City Hospital and City Home on Blackwell's Island, New York. The main objects of the institution include the prosecution of researches into the diseases of old age.

Dr. J. J. Pursel has been elected Anæsthetist to Dr. Stevens' Hospital, Dublin, in room of Dr. J. L. Bell, resigned.

The honorary degree of M.D. was last week conferred by the University of Dublin on Dr. Conolly Norman and Dr. Philip Henry Pye-Smith.

A CLINICAL LECTURE

ON

SOME OF THE ORGANIC CONSEQUENCES OF HIGH BLOOD PRESSURE (a).

By LEONARD WILLIAMS, M.D., M.R.C.P.,

Physician to the French Hospital; Assistant Physician to the Metropolitan Hospital.

THESE five patients are here to illustrate some of the many morbid conditions which are associated with high blood pressure. In the minds of a great number of people high blood pressure suggests one morbid condition only, namely, granular disease of the kidneys. Such, however, is a very restricted view of the matter which, in the light which the manometer has afforded us, is no longer justifiable. Arterial hyper-tension is now very generally admitted to exist as a primary condition ; it is only when it has been in operation for a considerable length of time that organic changes supervene. Something, of course, must give rise to the hyper-tension itself, and this something in the majority of cases is the absorption of toxins from the gastro-intestinal canal. The stages through which the process passes, therefore, may be described as auto-intoxication ; high arterial tension, arterial degeneration. Arterial degeneration, as we know, is of two kinds : (1) that which affects the larger arteries and is called atheroma ; (2) that which affects the smaller arteries and arterioles and is called arterio-sclerosis. The burden of atheroma is borne by the aorta and the heart. In the former it provokes aneurysm, in the latter it gives rise to aortic valvular disease, and, by involvement of the coronaries, to angina pectoris and myocarditis. It is well, then, to remember that if we can recognise and arrest hyper-tension in its functional stage we may save our patient from these dread maladies. Arterio-sclerosis being a degeneration of the smaller vessels, it may of course appear in any tissue or organ, and when it is more marked in certain particular organs than it is in the system generally, a distinctive name is given to the condition, and we are in consequence apt to lose sight of the fact that hyper-tension may be at the bottom of the disease so designated. Thus it is that granular disease of the kidney and hepatic cirrhosis are often considered primary events, arterial hyper-tension being regarded as a result rather than as the cause of the disease. If we learn to look at the matter from the other point of view, and consider the sclerosis of the organ as a part of a general arterial sclerosis which has been induced by long continued high tension, the nature of these processes becomes very much more comprehensible. The functional stage of hyper-tension is one to which very much less importance is usually attached than its gravity merits. This is partly because its symptoms are very indefinite (breathlessness on slight effort being the only one which is at all prominent). and largely because its detection can only certainly be effected by the use of a manometer, an instrument the use of which is still unfortunately confined to the few.

The use of the manometer is certainly liable to be irksome, and as none of the reliable instruments are very portable, it may still be a long time before it vindicates its real value. In the meantime, in your endeavours to form an estimate of the state of the blood pressure without such assistance, I cannot insist too strongly upon the danger of trusting to mere palpation of the radial artery. Here, for example, is a man æt. 50, whose pulse, when felt, will be found to be perfectly compressible, whose radial artery seems to present nothing strikingly abnormal, who nevertheless has a very high blood pressure. The history of my association with him is interesting and instructive. He was admitted into the hospital with a profuse hæmoptysis, on the subsidence of which my house physician very properly examined his chest, and thought he detected some signs of tuberculosis. When I came to confirm this diagnosis, I found myself quite unable to do so. The lungs seemed to me to be quite free from any serious disease. The question then naturally arose : how was the undoubted hæmoptysis to be explained ? There was no phthisis, there was no mitral stenosis, the size of his heart was normal, there were neither casts nor albumen in his urine, and although he has a little emphysema, it did not seem to me to be a sufficient cause for the profuse hæmorrhage from which he had suffered. I therefore took his blood pressure with Dr. Oliver's new instrument, and found it registered 190 mm. Hg. This I regarded as a sufficient explanation of the hæmoptysis. My house physician wanted to know how high blood pressure in the systemic circulation could give rise to a hæmorrhage from the vessels in the pulmonic, the lesser, circulation. That is a very pertinent question, for it is obvious that the interposition of the capillaries, the veins and the valves of the right heart, render the pressure in the two systems absolutely independent of one another. It is of course true that if from any cause there is hyper-tension in the pulmonic circulation, there must inevitably be hyper-tension in the systemic circulation, because the pressure on the systemic side must always rise higher than the pressure on the pulmonary side. This is only another way of saying that arterial pressure must always be higher than venous pressure. As soon as this ceases to be the case the medulla is starved and the patient dies. It is also true that the same cause which produces hyper-tension in one system may produce it in the other, that is to say, the toxins acting on the interior of the vessels so as to bring about their contraction, may act as powerfully in the pulmonic circulation as they do in the systemic. This, however, though theoretically true, is uncommon, and need not therefore detain us. But the important point to remember is that hæmoptysis may, and very often does, occur even when the pressure in the pulmonary circulation is low. We are rather too apt to think of hæmoptysis in terms merely of the lesser, the pulmonary circulation ; we are rather too apt to forget, that is, that the lung substance itself is supplied with blood from the systemic system through the bronchial arteries, which are of course branches of the thoracic aorta, and that when there is hyper-tension in the systemic system, one of these arteries or their branches are liable to rupture. Such, I believe to have been the cause of the hæmoptysis in this man's case, high arterial tension with rupture of one of the branches of the bronchial arteries. The arteries in the lung, though better supported than those in the brain, are not as well supported as those in the ordinary systemic circulation. We do well, therefore, to remember that, after the brain the lung is perhaps the most frequent site for the rupture of a systemic artery.

(a) Delivered at the Medical Graduates' College and Polyclinic.

This next man shows a different stage of high blood pressure, for he has, I think, without doubt granular disease of the kidney. Unlike the first patient he has albuminuria and definite cardiac involvement. His heart's apex is outside the nipple line, and he has a reduplicated first sound, the sound which is very aptly described as a "bruit de galop." Now, these bruits, which are created by the interposition of an extra sound, are sometimes very difficult to distinguish the one from the other, but this sound, a true galop rhythm, which is as much apparent to the palpating hand as it is to the ear, is characteristic of definite cardio-vascular involvement. I do not ever remember to have heard it, in the form in which it is here present, except in a case of arterio-sclerosis or renal cirrhosis, which, as I have said before, are in reality but two different names for the same thing. A true "bruit de galop" consists of two short sounds and one long, and is best appreciated at the apex. The doubling of the second sound for which it ought not to be mistaken, though it sometimes is, consists of one long and two short, and is best heard at the base. This doubling of the second sound is due to asynchronous closure of two sets of basal valves, and is not in reality a "bruit de galop." The true "bruit de galop" is a pre-systolic sound, and is therefore very easily confused with the pre-systolic doubling of the first sound which occurs in early mitral stenosis. In early mitral stenosis the valves are thickened, and as the auricle contracts, the steam forces open the stiffened mitral segments, thus causing the extra sound. The French called it "*le claquement de l'ouverture de la mitrale.*" In arterio-sclerosis, the mechanism is somewhat similar. The auricle contracts and forces the stream of blood through the unimpaired valve, so that it impinges against the wall of the left ventricle, before the latter is fully dilated. The tardiness of the left ventricle in accomplishing its diastole is due to the fact that it is no longer purely muscular, that its substance has become invaded by fibrous tissue. This degenerative myocarditis represents the final stage of the process which beginning as functional high tension, leads progressively to arterial degeneration and cardiac involvement.

Inasmuch as these two conditions, chronic degenerative myocarditis and mitral stenosis, are both characterised by dyspnœa, that in both there may be hæmoptysis and œdema, and that in both the systemic blood pressure is liable to be very high, it is not surprising that in certain cases confusion may creep in. The importance, therefore, of ascertaining the real size of the heart by careful percussion cannot be over-estimated. In mitral stenosis the enlargement is to the right, in myocarditis the enlargement is to the left.

Where the mitral stenosis is accompanied by mitral regurgitation, the left ventricle may indeed be enlarged, but even so, the bulk of the enlargement will be on the right side, whereas in arterio-sclerosis the bulk of the enlargement is always on the left.

This next patient came to hospital complaining that though he could point to nothing which was definitely wrong with him, he had been feeling out of sorts for several weeks. When I came to examine him I found that he had a blood pressure of over 200 mm. Hg., and that his liver was enlarged, practically to the level of the umbilicus. His heart sounds are very difficult to hear, especially the systolic sound at the apex, but his aortic second sound is definitely accentuated. He has no murmurs or interpolated sounds, and his urine is free from albumen and casts. The case I believe to be one of hepatic cirrhosis of the alcoholic type, and I believe it to have been induced by high arterial tension whose long continuance unchecked has caused a sclerosis in the vessels of the liver. The subject of the causation of hepatic cirrhosis is not one which invites to dogmatism, but I submit that this view, which is very generally taught in France, serves to explain a good deal which on all other hypotheses must remain obscure. Moreover, cirrhosis of the liver of the alcoholic type is admittedly associated with general arterio-sclerosis and degenerative disease in the kidneys and heart. The hepatic manifestation may be regarded then as a part of a general toxæmia, the first physical sign of which has been a functional hyper-tension, leading insensibly to degenerative disease in the arterioles of the organ.

The two remaining patients are both women, and, characteristically enough, they display the results of their hyper-tension in the domain of the nervous system. This woman comes to us with the story of an attack of unconsciousness followed by a loss of power on the left side of the body—in point of fact a hemiplegia. There seems no reason to doubt the accuracy of her statements, because in out-patient practice we are familiar with numerous cases of a similar kind. These people have attacks of unconsciousness followed by paresis of one side of the body. They are admitted to the wards, and a short time afterwards they are discharged perfectly well. In the cases to which I refer, although the loss of power is quite definite, there are never any subsequent signs to indicate the existence of descending degeneration in the spinal cord. If you will examine this woman you will find that she has no ocular phenomenon, that her tongue is protruded mesially, that her grasps on both sides are equal, that her knee jerks are present, moderate in extent, and equal on the two sides, and, further, that she is free from ankle clonus, and that her plantar response is flexor. Now what is the explanation of these cases? The causes of hemiplegia are hæmorrhage, thrombosis, embolism and new growths. But it is obvious that any one of these, if sufficiently severe to give rise to an attack of unconsciousness must destroy a certain portion of the brain substance and give rise to permanent impairment of function. In this woman nothing of the kind has happened. We are justified therefore in assuming that whatever the cause of her hemiplegia, it was not one of the four classical causes which are generally recognised. There was in our grandfather's time a condition which used to be spoken of as "serous apoplexy" and I am strongly inclined to believe that the physicians of those days were right in their contention that such a condition can exist. If, for instance, we suppose a greatly increased fulness in the cerebral vessels, the inevitable result would be a filling of the ventricles and a pressure applied in all directions to the substance of the brain. Why that pressure should affect one side more than another, it is no more possible to explain than why it is that one artery should rupture in preference to another. When this woman came to see us, I thought I would test this view of the question by measuring her arterial tension, and I found that it was no less than 190 mm. Hg. Now if it stands at that figure generally, to what height must it rise in states of excitement or in such other conditions as we know to be capable of increasing the inter-vascular tension ? And if in such conditions it rises, as we may assume that it does, another 20 or 30 mm., it is not very difficult to believe that the pressure within the cranium may be such as to cause an effusion into the ventricles, and so press upon one of the internal capsules as to give rise to a passing hemiplegia. For we have to remember that the vessels in the brain are endowed with a power of contraction so slight that some competent observers still doubt its existence. A general rise of blood pressure would therefore certainly give rise to an overfulness of these arteries.

This last case is one of ordinary Bell's palsy, that is to say, a paralysis of the left side of the face unaccompanied by any condition which would lead us to suppose that the seventh nerve inside the cranium is organically affected. I need not remind you of the methods at our command for determining the exact seat of the lesion which may cause a facial paralysis of the peripheral type. The points are dwelt upon in the text-books and are beloved of examiners. The anatomical fact to which I want to direct your attention is well shown in this diagram of the cerebral arteries at the base of the brain in "Quain's Anatomy." There you will see that the anterior inferior cerebellar artery is given off by the basillar as soon as the latter has passed from the medulla to the pons. The branch as it passes outwards threads its way between the 6th, 7th, 8th, 9th, 10th, and 11th cranial nerves, and it is a remarkable fact that it passes over them all except the 7th and 8th, which two it passes under.

Now these cases of Bell's palsy are, as you know, described as "rheumatic" in origin, which is merely another way of saying that we have not the slightest idea as to their cause. "Rheumatic" to the ætiologist is an even more blessed word than ever Mesopotamia was to the theologian. I suggest that the anatomical distribution of this anterior inferior cerebellar artery may supply us with the explanation of this condition, whose cause has hitherto seemed so obscure. This woman, for example, has no rheumatic or "chilly" history, but she has a very high blood pressure. Her artery as it crosses these two nerves is therefore presumably distended. If, by emotion or "chill" or what not, this distension becomes augmented, it is not difficult to imagine that the vessel might exercise sufficient pressure upon the seventh and eighth nerves to give rise to serious, if temporary, embarrassment of function. In support of this explanation is the fact that this patient had a certain amount of deafness which accompanied the onset of her palsy ; the deafness and the palsy having disappeared coincidently. In further support of facial paralysis of the so-called "rheumatic" type having some causal relationship with high blood pressure is the fact that the only drug which hitherto has seemed to be of any service in the paralytic condition is iodide of potassium, and iodide of potassium, as we know, is a powerful reducer of blood pressure. The element of increased blood pressure in the causation of this affection is therefore one which seems to be deserving of more attention than it has hitherto received.

In endeavouring to come to a conclusion on the subject of the state of blood pressure when no instrument is available, I have already pointed out the futility of palpating the pulse at the wrist. A far more satisfactory method of arriving at a general conclusion is that of estimating what the French call the stability of the pulse. The pulse rate, we know, is normally 6–8 beats more rapid in the upright posture than it is in the recumbent. If this difference tends to become abolished then the probability is strong that the pressure in the arteries is unduly high ; and if it becomes reversed, so that the rate in the recumbent posture is greater than that in the upright, not only is it certain that the pressure is unduly high, but the probability is great that matters have progressed to the point of producing definite organic disease. This probability is rendered even more pronounced if, on examining the heart, we find the apex beat displaced to the left, a sign which by some authorities is considered as undoubted evidence that there is a sclerosis of the arteries in the splanchnic area.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by E. Percy Paton, M.S., F.R.C.S., Surgeon in Charge of Out-Patients to Westminster Hospital. Subject : "Some Observations on Intra-Abdominal Adhesions with Illustrative Cases."*

ORIGINAL PAPERS.

THE TREATMENT OF TYPHOID FEVER.

By E. STADELMANN, M.D.,

Hofrath Tit. Professor der Innere Medizin, and Director of the Städtl. Krankenhaus am Friedrichshain, Berlin.

The strivings after a specific form of treatment have, unfortunately, not led us much further. A serum, by means of which we could cut short typhoid, or modify or shorten its course, still remains undiscovered. The preliminary report of prophylactic inoculation appears to have given better results. Both in the Boer war in South Africa and in our own field-work in South-West Africa, typhoid fever has claimed its terrible sacrifices. The number of infections after preventive inoculation with deadened typhoid cultures carried out at home are said to have been considerably diminished. The breadth of bearing of this observation cannot be seen at a glance with any certainty, and at the present time no physician is in a position to be able to recommend preventive inoculation to those belonging to the families of those ill of the disease, somewhat in the same way as is done in the case of diphtheria, and often with good results. Wherefore the strivers of older dates who sought for an abortive treatment of typhoid fever have still many adherents. Liebermeister, to this end, recommended treatment by iodine—1 part iodine, 2 parts potassic iodide, 10 parts water, of which 3 to 4 drops were to be given every four hours in a glass of water, or potassic iodide alone in doses of 1 to 4 grm. daily. The calomel treatment had the same aim—2 to 3 doses of 0.2 to 0.3 grm. in the twenty-four hours for one day in the first or second week of the disease. It is quite conceivable that with the copious stools following the medicine, a good deal of infectious material was removed from the bowel, and that a certain amount of intestinal disinfection was obtained. I have often thought I had seen good results from this procedure in recent cases. But, on the other hand, I have never seen any from the administration of naphthalin, naphthol (40 grm. in one dose), or bismuth salicylate, which *should* also have a disinfecting action in the bowels.

Independent of the general management of typhoid patients (rest in bed, arrangement of the room, &c.) that is generally understood, the diet is of eminent importance. The food must be fluid, easily digested and absorbable. That many body substances, especially body albumen, are destroyed under the influence of the re-absorbed toxines, and of the fever, is undoubted, and it is impossible to prevent the consequences of this destruction by giving large quantities of albuminates and other feeding material. It must naturally be our endeavour to prevent the loss of bodily substance as much as possible, but this can only be effected by giving chiefly carbohydrates. The sickly organism does not bear flesh meat even in the mildest forms, and the patients object to taking it, and there are great difficulties in the way of giving fats, and even carbohydrates. In the first line in typhoid cases we must fall back on milk, which later on we may make more palatable to the frequently-objecting patient by the addition of coffee, cocoa, oatmeal. Milk soups, meat broths, soups of meal, rice, groats, even children's prepared foods, afford further changes, which we can make more nourishing by the addition of yolk of egg. The various artificially-prepared foods may also be tried, but more important and more nourishing is an egg in a glass of milk. Gelatine substances are an important nitrogenous food material which can be given to the patient as meat jelly, wine or fruit jelly. Fats are, at the most, to be given in the meals or groat gruel; cream, as whipped cream, with sugar, should be tried. Carbohydrates are best given in the form of sugar in the drinks, and a trial should be made of preparations of malt, In the feeding of typhoid cases it should be the rule to give something every two hours. In practice, however, when the patient is so often opposed to it, and there is as often a tendency to vomit, it is sometimes a very difficult thing to do. But you must not lose patience; you must still coax and try something new and novel.

A question as important as that of food is that of the drinks. The fever patient, with his raised temperature, requires a deal of water; he lies more or less in a semi-conscious state with half-open mouth, mouth, tongue, palate and fauces dried up, and a strong feeling of thirst is the outcome. We must not only satisfy this, but we must *make* the patient drink. Pure, fresh water is in the end the best taken by the patient, but there is no objection to the various lemonades. An excellent drink for quenching thirst is weak, sweetened, cold tea. A warning must be given as regards mineral waters that act as aperients or that distend stomach and intestines with carbonic acid gas. There is no objection to small doses of alcohol; large doses, such as were formerly given, are dangerous and even hurtful. The stimulating action of alcohol has not been proved, and our pharmacopœia offers us endlessly better and less harmful stimulants than that agent, and it possesses no antifebrile properties whatever.

THE ANTIPYRETIC METHODS OF TREATMENT.

I. Hydrotherapeutics.—In regard to fever, there are, as is known, two opposite views. The one, the older, sees in it a factor destructive to the organisms that must be combatted with the most powerful remedies; the newer view considers the fever as a protection to the organism against the toxic substances that have found their way into it. The truth here lies between the two; unusually high and long-continued high temperatures certainly result in serious mischief to the organism. But the fever alone does not dictate the treatment; the experienced physician does not judge of the severity of the disease from the height of the temperature alone; the patient's general condition is of far more importance to him. Experience teaches that cold baths, independent of the lowering of the temperature, act favourably in quite other directions. They make the sensorium freer, the pulse becomes stronger and less frequent, the morbid conditions of the respiratory tract improve, or they are arrested at the onset, food is better taken, the skin is properly cared for by the very treatment itself; decubitus, that occurred so frequently in former times, is avoided, the patients breathe more calmly and freely, the urine and stools are no longer voided involuntarily, &c. We have therefore arrived at quite different views as to the kind and manner of hydrotherapeutic treatment, as well as the indications for it. I have given up the former rule of ordinary baths at 16-12-10 (R), as soon as the temperature in the axilla has reached 39.5 (C), and content myself with cool or lukewarm baths at 30 to 32 (C). Here also one sees the temperature fall 1 to 1½ to 2 degrees, and the favourable influence on the general condition manifests itself. It is certain that in later time, even if the dangers of typhoid fever are unchanged, the temperature curves are undoubtedly considerably altered. The temperature curves, with a constant high temperature lasting two to three to four weeks, I have not seen for years. The fever has from the first a pronounced intermitting character, and maintains it through the whole duration of the fever. The baths are begun early, and continued until the fever ceases. Two or three a day are given generally during the height of the disease. If the temperature in the morning is normal one bath only is given, and that towards evening.

Of other hydratic forms of treatment to be mentioned are cold douching, which is not advisable, wet packings, which have only a slight effect, sponging of the body with cold water (not over 12 R.), with vinegar and water, 1 part to 4. The procedure is a mild one and may be used when baths, from any cause, are not allowable; the washing, if it is to be serviceable, must be repeated every two to three hours. The protracted warm baths introduced by Riess at a temperature of 25 to 27 R., in which the patient lies for hours, are used especially for very excitable patients as well as for alcoholics, and have a very soothing effect. The bed-bath, introduced by Krönig, may also be mentioned, of which I have no experience.

Bath treatment must be unconditionally forbidden in cases of intestinal hæmorrhage, peritonitic irritation, as well as in peritonitis. One must be very cautious in cases of cardiac weakness, cardiac diseases, arterio-sclerosis, old heart failure, tuberculosis, bronchiectasis, that is, diseases with a tendency to hæmorrhage from the lung tissues, in emphysema of the lungs, in old fatty people, in chlorosis, anæmia, and alcoholics. Priessnitz packings, when baths are not available, are quite suitable.

II. Antipyretic Medicines.—A large series of febrifuges have been used, quinine, antipyrine, phenacetin, antifebrin, lactophenine, pyramidon.

These I practically never give, as I have become convinced that no real advantage can be gained by them. Antipyrin has very unpleasant bye-effects as regards the stomach; phenacetin and antifebrin are poisonous drugs best altogether eliminated from the physician's armamentarium. In regard to lactophenine, which in doses of from 4 to 6 grm. daily brings about a prompt reduction of fever, I have no experience. Pyramidon is said to act in a similar way, but I cannot join in its praise. Often, in doses of 0.25 to 0.30, given five times a day, it has failed to reduce the temperature for any length of time. Vomiting often took place after it; loss of appetite, and profuse sweating distressed the patient very much. The salts of pyramidon do no better. Quinine acts best given in one dose of 1 grm. to 1½ grm. before the height of the fever. But even this drug has so many disadvantages (singing in the ears, a species of intoxication, deafness and feeling of unwellness, tremors, and even collapse), that I now scarcely ever use it in typhoid; it cannot be compared to the treatment by baths.

The Treatment of the Disturbances on the Part of the Various Organs.

The disturbances of the central nervous system (somnolence, apathy, restlessness, delirium, sleeplessness, &c.) are influenced in the most favourable manner by the baths. With them an ice-bag may be applied to the head. In case of great restlessness and insomnia a morphia injection of 0.01 to 0.015 grm. may be given with a favourable effect on the general condition also. On the side of the circulatory apparatus the dangers of threatening cardiac weakness are very great. In such cases of collapse I have never seen any real good from alcohol. It is much more important to make use of the excellent excitants we have in our pharmacopœia. Digitalis does not act favourably, and is very often badly borne. On the other hand, early subcutaneous injections of Ol. camphoratum and natrosalicylate of caffeine (in heroic doses 1 to 2 syringefuls of a solution of 2 : 10 every two hours); æther is uncertain in its action, and extraordinarily painful. The intestinal tract demands special careful supervision and therapeutic treatment. Moderate diarrhœa requires no medicinal treatment; on the other hand, if it is profuse I prefer giving ten drops of tinct. opii. in a mucilage or starch enema. Excessive meteorism is very favourably influenced by bismuth subnitrate or subsalicylate, the application of an ice-bag, or the insertion of a rectal tube. If the bowels are blocked, no aperient must be given, but a mild enema or injection of oil.

In hæmorrhage from the bowels, even if of the slightest, absolute rest, limitation of diet and drinks, and the baths must be stopped. If the hæmorrhage is severe, only pills of ice should be given for the thirst. Medicinally, acetate of lead, 0.05 to 0.1, every hour or two, dialyzed ext. ergotæ 2 : 10, a syringeful every half hour or every hour, stypticine 0.03 to 0.1 several times a day by subcutaneous injection, gelatine (pure) injected in a 2 to 5 per cent. solution, at first 4 grm. at once, then twice more in a dose of 2 grm. at intervals of a day or two. An absolutely reliable (sterilized) preparation is made by Merck, of Darmstadt, the solution being already prepared and put up in sealed vessels. Adrenalin, 10 drops of a 1 : 1,000 solution, every two hours for a day or two days. I have never been able to convince myself with certainty of the beneficial action of the two remedies last named. In case of violent and repeated epistaxis, careful tamponnade of the nostril affected from behind.

When perforation of the bowel takes place the prognosis is almost hopeless. Absolute rest, prohibition of all foods, and even fluids. Whether any real good is obtained by operative measures I do not know. In addition to rest and cold applications, opium and morphine should be given to keep the bowels quiet, and to favour the formation of adhesions and the relief of pain.

For the prevention of extensive catarrh of the lungs and pneumonia, cold water treatment is the most suitable. Decubitus must be avoided with the most painful care; typhoid patients must be placed from the first on a water-cushion, and in furtherance of avoidance of the mischief, bath treatment is still the best on account of the cleanliness and care for the skin associated with it. On the first sign of its appearance the part must be rubbed with spirit of camphor, boric lanolin, or boric vaseline. If decubitus has already appeared, a dressing of antiseptic remedies must be ordered, amongst which a 1 in 30 dressing of balsam of Peru is suitable. Great care must be taken regarding the onset of an attack of nephritis, in consequence of toxic material either taken into the system or arising from the typhoid bacilli themselves. If the bladder becomes paralysed the catheter must be made use of.

Relapse and recurrence are to be looked upon as very dangerous; their treatment does differ from that of the original fever, but on account of the organism being already weakened by the preceding illness, the greatest caution is necessary, especially as regards treatment by baths.

After convalescence has set in, the fluid diet must still be continued for a week; not till then may the patient take more solid food in the shape of soaked and softened biscuit (Zwiebach) or English biscuit, gruel, &c. Flesh meat must not be given for ten or fourteen days, and then either scraped or minced. After the third week the ordinary diet may be given. Exceedingly strict warning must be given against any errors in diet; even if they cannot cause a relapse they can, at any rate, favour the onset of one, as the virulent bacilli still present in the intestines may, after any error of diet, possibly set up a new disease.

In milder cases, if the patient is not too much run down, he may attempt to get up after the fever has been away for a fortnight; but in severe cases not until after three or four weeks. The time for being out of bed may gradually be lengthened, and if the weather is fine the patient may go out after the fourth week. The usual vocation should not be returned to until after another six or eight weeks' recuperation. The consequence of returning to work too early and before the powers have become restored is a long lingering feeling of lassitude, inability to work properly, and general feeling of not being well.

A NOTE ON RHINORRHŒA IN FAUCIAL DIPHTHERIA.

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From an early stage in the history of diphtheria the occurrence of nasal discharge preceding or accompanying the angina has been well known. Misled by the fact that a nasal discharge, apparently benign in nature, may sometimes precede very severe diphtheria, Bretonneau, who first established diphtheria as a specific disease, formulated the law that diphtheria always has a nasal origin. The nasal fossæ according to him were the nest from which the membrane is carried to the lower parts. The exaggeration of this statement was obvious. Trousseau, between whom and Bretonneau a controversy arose, had no difficulty in showing that diphtheria is not always preceded by a nasal discharge, and fell into the opposite error of denying the possibility of the nasal onset of diphtheria. Membranous coryza, according to Trousseau, was merely a complication of the angina. The question of the nasal origin of diphtheria was soon forgotten, and it is only within the last few years that it has been revived by Sevestre, who states that careful inquiry from the parents of children affected with faucial diphtheria will often elicit a history of a nasal discharge. More recently Marfan has declared that while it is rare for a child to complain of a sore throat at the very beginning of diphtheria a mucous hypersecretion of the nostrils at that time is not uncommon. The pharyngeal tonsil, according to Marfan, is probably the site of origin of diphtheria. It is obvious that pre-existing adenoids would predispose to diphtheria originating in such a spot. The frequency of adenoids in fatal cases of diphtheria has been shown by Cottier, who in 38 autopsies on diphtheria patients found adenoids in 50 per cent.

The great authority of Trousseau is responsible for the erroneous doctrine that a nasal discharge in diphtheria is invariably of bad omen. "Coryza, even of a slight degree, is a serious occurrence, for it indicates that the specific phlegmasia has invaded the nasal fossæ. . . . Of 20 individuals affected with nasal diphtheria 19 succumb, while of 20 affected with croup you can save a certain number by tracheotomy." Two subsequent writers of the pre-antitoxin era, Cadet de Gassicourt and Henoch, showed that Trousseau's statements were too absolute, both asserting that a nasal discharge during the acute stage of diphtheria was compatible with a mild attack. The truth of this view is confirmed by my own experience, as will be seen below.

The present paper is based on 1,200 consecutive cases of diphtheria that have been under my care in the course of the last four years. Of these, 323, or 26.91 per cent., on admission to hospital, or subsequently during the acute stage, presented a discharge from the nose. There was also a history of recent nasal discharge since the commencement of the disease in 177 others (14.75 per cent.), though in them no nasal discharge was observed either on admission or subsequently. Thus a total of 500, or 41.6 per cent. of all the cases had some nasal involvement. (*a*) These figures are probably too low, for a slight degree of nasal discharge before admission to hospital may have escaped the notice of the patient or his friends. Further, it must be borne in mind that the absence of rhinorrhœa, or of visible membrane in the nostrils, does not necessarily imply that no nasal diphtheria exists. The nasal membrane may, as autopsies show, be limited to the posterior part of the nares, from which the discharge passes down into the pharynx instead of externally.

As only four of the 177 cases with nasal discharge prior to admission had received antitoxin before admission, and two of the four on the same day that they were admitted, it is obvious that nasal discharge may cease spontaneously. This is most likely to occur in cases which run a mild course, as is shown by the following tables, from which it is seen that, while the self-limiting nasal discharge becomes progressively more frequent in the milder cases, the more persistent nasal discharge becomes progressively more frequent in the severer cases.

Table I.—Cases in which nasal discharge occurred as a prodromal symptom, but was not present on admission to hospital or subsequently.

Character of Faucial Attack.	Total Number of Faucial Cases	Cases with Prodromal Nasal Discharge.	Percentage.
Very severe	121	9	7·43
Severe	225	24	10·6
Moderately severe	108	12	11.1
Moderate	305	53	17·37
Mild	428	79	18·45
	1,187(*b*)	177	

Table II.—Cases in which nasal discharge was present on admission, or developed subsequently during the acute stage.

Character of Faucial Attack.	Total Number of Faucial Cases.	Number of Cases with Nasal Discharge.	Percentage.
Very severe	121	89	73·55
Severe	225	112	49·77
Moderately severe	108	30	27·7
Moderate	305	48	15·73
Mild	428	44	10·28
	1,187	323	

Further evidence of the greater severity of the cases in which the nasal discharge persisted until admission is afforded by the following figures. Out of 92 deaths in the 1,200 cases 16, or 1·8 per cent., occurred in the purely faucial cases, among which are included those which had a history of nasal discharge prior to admission only; 14 or 11.1 per cent. occurred in the faucial and laryngeal cases; while in the faucial and nasal cases there were 59 deaths, or a mortality of 18·2 per cent. Intercurrent diseases were responsible for 3 deaths, two being due to scarlet fever, and one to congenital syphilis.

The incidence of albuminuria and paralysis, the frequency and severity of which bear a direct relation to the character of the initial attack, was greatest in the nasal cases. Thus, among the purely faucial cases there were 135 paralysis cases (15·6 per cent.), 27 of which were severe, while in the faucial and nasal cases there were 143 paralysis cases (44·2 per cent.), 59 of which were severe. So with albuminuria. In the faucial and nasal cases there were 215 albuminuric cases (66·5 per cent.), in 32 of which the albumin persisted for three weeks or more; in the purely faucial cases there were 395 albuminuric cases (45·8 per cent.), in 19 of which the albumin was present for more than three weeks.

In the cases of self-limiting nasal discharge the rhinorrhœa was a very early symptom starting as a rule at an earlier date than the nasal discharge which persisted until admission.

This is shown by the following tables :—

Table III.—Day of disease on which a nasal discharge was first noted in cases which on admission and subsequently had none.

(*a*) Seven purely laryngeal cases and six purely nasal cases which have not been included complete the 1,200 cases.

(*b*) Very similar figures are quoted by Glatard, who says that out of 177 cases of diphtheria admitted to the Hôpital Bretonneau, 42.9 per cent. contained diphtheria bacilli in the nose. The great majority of those cases showed clinical evidence of nasal diphtheria as well. It pre-antitoxin times Garnier (quoted by Glatard) found nasal diphtheria in 41·05 per cent., or in 39 out of 95 cases.

1st day	88 cases
2nd „	43 „
3rd „	28 „
4th „	6 „
5th „	7 „
6th „	5 „
	177 cases

Table IV.—Day of disease on which a nasal discharge was first noted in cases in which it was present on admission or subsequently.

1st day	89 cases
2nd „	69 „
3rd „	68 „
4th „	50 „
5th „	37 „
6th „	6 „
7th „	4 „
	323 cases

Though the self-limiting nasal discharge was more common in young children it was not confined to them; 26 out of the 177 cases occurred in patients between the ages of 10 and 36 years.

A previous history of recent nasal discharge was more frequent in the laryngeal cases than in those which were purely faucial. Out of 133 laryngeal cases in the 1,200, 31, or 23.3 per cent., had such a history; while out of 861 purely faucial cases, 152, or 17.65 per cent., had had a nasal discharge at the beginning of their illness. It is interesting to note that in three out of seven cases (42.8 per cent.), which on admission were clinically cases of purely laryngeal diphtheria, there was a recent history of nasal discharge. Such cases are especially likely to occur in very young children. The nasal diphtheria of infants usually remains localised to the nose, but it may spread, the membrane passing down the sides of the pharynx, where it may easily escape observation. In seven cases of nasal diphtheria in nurslings recorded by Ballin there were two in which the larynx was affected.

Summary.

1. A large percentage of all cases of faucial diphtheria admitted to hospital has a history of rhinorrhœa.
2. In a certain number of cases which clinically are purely faucial, rhinorrhœa is an early symptom, subsequently disappearing without treatment.
3. The frequency of this early and transitory rhinorrhœa bears a direct relation to the mildness and an inverse relation to the severity of the faucial attack.
4. Faucial cases which are also clinically nasal are more severe than those which are clinically faucial only.
5. Faucial cases which are also clinically nasal as a rule develop the nasal discharge at a later date than those which are clinically faucial only.
6. Early and transitory rhinorrhœa is relatively more common in laryngeal cases than in those that are purely faucial.

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URÆMIA (*a*).

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The purpose of this paper is to put forward the proposition that there is evidence to show that the cerebral manifestations of uræmia are dependent upon cerebral anæmia, produced by an increase in intracranial tension resulting from cerebral œdema. In other words, the old and abandoned hypothesis of Traube will be reconsidered in the light of recent experimental and clinical work on conditions of increased intracranial tension with their associated alterations of blood pressure.

(1) The Physiological Results following Increased Intracranial Tension.

This question has been studied experimentally by Harvey Cushing (*b*). He increased intracranial tension in dogs by trephining and applying pressure to the surface of the brain by means of a distensible rubber bag, communicating with a burette containing mercury. He showed that if the intracranial pressure be rapidly increased, "Kussmaul Tenner spasms, evacuation of bladder and rectum, practical cessation of respiration, and pronounced vagus effect upon the heart, often with a complete standstill, lasting from ten to twenty seconds, may develop. Then follows a release from this extreme vagus inhibition and the vasomotor centre exerts its influence." With a slower increase of the intracranial pressure a different series of events occurred. The pressure against the brain could be increased to the point of its equalling the blood pressure before any symptoms referable to the centres in the medulla were called forth. Direct examination of the cortex through a circular disc of glass fitting tightly into a second trephine hole showed, at this period of equalisation of blood pressure and intracranial tension, an *abrupt blanching* of the exposed convolutions. The pulsating arteries could be seen against the blanched background and the dark blue veins in the sulci remained filled with blood, but presumably little, if any, circulation passed between them. The usual consequence was not death but *a stimulation of the vasomotor centre, which occasioned a rise in blood pressure sufficient to overcome the high intracranial tension*; the cerebral circulation was re-established and the rosy colour could be seen through the glass window in the trephine hole to return again to the blanched convolution. With further increase in intracranial tension the blood pressure rose *pari passu*, and always to a point exceeding the intracranial tension. This process could be repeated until the arterial pressure was forced to two or three times its normal level, sometimes to as much as 250 mm. Hg., without evidence of vasomotor failure.

If by division of both vagi their influence on blood pressure and pulse rate were cut out, the blood pressure followed the increase of intracranial tension even more closely. If the spinal cord were divided in the cervical region, and thus the vasomotor control of the great splanchnic area lost, then increase in the intracranial tension produced only a vagus slowing of the pulse with no rise of blood pressure; while if both cord and vagi were divided no alteration whatever in either pulse or blood pressure occurred on increasing the intracranial tension. In face of these experiments Cushing's conclusion that an increase of intracranial tension occasions a rise of blood pressure which tends to find a level slightly above that of the pressure exerted against the medulla seems absolutely justified. By this mechanism the vital centres in the medulla and the life of the brain and entire animal are protected.

(*a*) Read at a meeting of the West London Medico-Chirurgical Society, December 7th, 1906.

(*b*) "The Regulatory Mechanism of the Vasomotor Centre which Controls Blood Pressure during Cerebral Compression."—*Johns Hopkins Bulletin*, Sept. 1901. For fuller account see also Cushing's Mütter Lecture for 1901, in the *American Journ. of the Med. Sciences*, Sept., 1902.

(2) Certain Clinical Conditions Associated with an Increase of Intracranial Tension.

It is well established that many of the symptoms of cerebral tumour, hydrocephalus, cerebral hæmorrhage, &c., are dependent upon an increase of the intracranial tension. Among such symptoms may be mentioned headache, vomiting, coma, convulsions, choked disc, &c. Extraordinary relief to these symptoms is attained after the pressure is relieved by surgical intervention. An admirable series of cases has been recorded by Harvey Cushing (*a*). In another paper Cushing (*b*) gives the records of five cases of intracranial hæmorrhage, four traumatic and one apoplectic. These illustrate from the clinical standpoint the facts ascertained by him experimentally. As the case of apoplectic hæmorrhage is of great importance I give it in detail.

Resumé.—Apoplexy with right hemiplegia, symptoms of pronounced intracranial tension evidenced by a blood pressure ranging about 300 mm. Hg.; threatened symptoms of medullary paralysis, major symptoms (bulbar) immediately relieved by craniotomy and aspiration of intracerebral clot, subsequent replacement of flap, death on the third day from pulmonary complications.

Man, æt. 40, admitted to hospital thirty-six hours after onset of symptoms. He was in a state of profound stupor with right-sided flaccid paralysis. Temperature 99.6°; respiration varied from 21 to 27; pulse 50 and of high tension, registering 300 mm. Hg. Conjugate deviation of eyes to right with nystagmus. Pupils equally contracted and reacted to light. Veins of forehead were greatly distended.

Operation.—A large osteoplastic flap was turned down over the left hemisphere. The dura was tense and without pulsation. On incising it the brain bulged far into the opening and began to pulsate actively. The convolutions were greatly flattened, deeply cyanosed, and the veins occupying the sulci were widely dilated, and their contents so dark that the colour contrast between veins and arteries was of an unusual degree. Blood was evacuated from the hemisphere by means of a grooved director, about two teaspoonfuls. The blood pressure began at once to fall and in twenty minutes had reached the normal level. The pulse rate during this fall in blood pressure remained unaltered. The release from intracranial tension was evidenced by the immediate collapse of the bulging hemisphere. On the following day the patient's condition had greatly improved. The pulse rate and blood pressure remained normal, respiration was no longer laboured, stupor was much less deep, and he could be roused with considerable ease. The conjugate deviation disappeared and he seemed to see and recognise objects. Stupor returned on the following day, though the blood pressure only rose to about 160 mm. Hg.; œdema of lungs set in, and he died two days later. *Post mortem*, a large hæmorrhage was found in the white centre of the left hemisphere.

The clinical evidence as obtained, therefore, from cases of cerebral tumour, cerebral hæmorrhage, &c., is in complete accord with the conclusions derived from a study of Harvey Cushing's experiments. To recapitulate—it is clear that a rise in intracranial tension by the introduction of any foreign element such as a tumour mass, blood, &c., must tend to diminish the blood flow through the brain. If the tension increases, a point would be reached at which the intracranial tension equals that of the general blood pressure. The cerebral circulation would therefore cease were it not that by a compensatory process the general blood pressure rises to a point above that of the intracranial pressure, and thereby maintains the flow of blood through the brain.

But with a great increase of intracranial tension, certain general effects are produced apart from focal symptoms dependent upon the position of the lesion. Headache, for instance, is common, and is probably attributable to tension of dura mater and tentorial structures. It is probable that the brain tissue itself is insensitive, and the fact that Cushing notes that after excision of the Gasserian ganglion for severe trigeminal neuralgia, any subsequent headache is only felt on the side with the intact fifth nerve, points in the direction that intracranial pain is experienced *via* the fifth nerve.

Optic neuritis is to be attributed, in the main, to a passive venous congestion of the retinal veins, and subsides or improves on relief of intracranial tension, sometimes with extraordinary rapidity.

Finally, coma is almost invariable in the last stages of cerebral tumour and in large cerebral hæmorrhages. Convulsions are also frequent in these conditions. Both are remarkably improved by methods capable of lowering the cerebral pressure, such as trephining or lumbar puncture. And it is to be noted that, by lowering the intracranial tension, a free access of blood to the brain is facilitated.

(3) Uræmia.

In cerebral uræmia we frequently see a symptom complex almost identical with that of cerebral compression, viz., headache, vomiting, drowsiness, coma, convulsions, optic neuritis, &c. This symptom complex is, at any rate in great measure, dependent upon increased intracranial tension, for many cases are now on record in which extraordinary relief has followed lumbar puncture, a procedure which, by means of allowing some of the fluid to escape, diminishes the pressure within the cerebro-spinal space.

Thus MM. Pierre Marie and Georges Guillain (*a*) record the case of a man, æt. 20, suffering from nephritis and epilepsy, who had suffered from severe headache for twelve months, with a high blood pressure (200 to 210 mm. Hg.). Lumbar puncture was performed, the cerebro-spinal fluid being under greatly increased tension, as it spurted out from the needle; 6 cc. were withdrawn. Within five minutes the headache was materially improved, and within two hours it had completely disappeared. Relief was complete for two days, when the communication was read. In the discussion which followed the paper, M. le Gendre recorded a similar case of relief. A man, æt. 57, painter, suffering from arterio-sclerosis and plumbism with albuminuria. He was uræmic with headache, myosis and insomnia. Lumbar puncture was performed, and 13 cc. withdrawn. The pressure was not noted. The same evening the headache was improving, and he slept well. The headache progressively improved, and in three days was absolutely gone.

In a further communication M. Pierre Marie pointed out that lumbar puncture for uræmia had been performed for the past six years in Germany, and he quoted three cases of cure of headache in saturnine encephalopathy, by Seegelken, Brash and Nölke. Marie, however, was careful to point out that other observers had not found lumbar puncture of help in the treatment of uræmia, and instanced as examples Quincke, Furbringer, Lichtheim, von Leyden, Stadelmann, Braun and Lenhartz. But he remarks that most of the above negative records were not accompanied by details of the circumstances under which the puncture was performed. G. Scherb (*b*) records a case of nephritis with uræmia in a man, æt. 49, suffering from very severe headache, and resisting all treatment. He was admitted to hospital almost comatose, with history of vomiting, auditory hallucinations and severe insomnia. Fundi showed slight venous stasis. Increased arterial tension. Incontinence of fæces. Lumbar puncture was performed, and 20 c.cm. removed, the fluid issuing in a spurt under considerable pressure. Within five hours he was conscious and could answer questions. Next day he was quite free from headache and remained so for six weeks, when

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(*a*) *Surgery, Gynæcology, and Obstetrics*, Vol. I., No. 4, Oct., 1905, pp. 297-314.
(*b*) *American Journ. of the Medical Sciences*, June, 1903.

(*a*) *Bull. et Mem. de la Soc. Med. des Hopitaux de Paris*, 1901, p. 427.
(*b*) *Revue Neurologique* (*de Paris*), Vol. X., 1902, p. 19.

it returned. Œdema also appeared, limited to the region of the forehead, eyelids, cheeks, lips, ears, and the skin of the scalp. Lumbar puncture was again performed, but with only temporary relief, and death occurred tens days later.

D. C. McVail records two very successful cases (*a*). In the first case a man with acute nephritis, with severe intracranial pain, followed by convulsive attacks repeated during thirty-six hours, became almost blind, and finally comatose. He was œdematous. Lumbar puncture was performed, the fluid issuing in drops, and apparently under no tension. Within twenty-four hours there was a return of consciousness and sight began to reappear. He slept well, and on the next day was free from pain, with perfect vision. This was followed by a rapid recovery from the renal condition. The second case was also one of acute nephritis, with moderate œdema. Within thirty-six hours of admission to hospital, and in spite of all treatment, he lapsed into deep coma. One ounce of fluid was withdrawn by lumbar puncture, again issuing in drops. Consciousness returned in four hours; he slept well, and next morning was quite rational. He also left the hospital free from albumen. McVail attributes the symptoms in these cases to increased intracranial pressure.

T. Arthur Helme (*b*), F. Proud (*c*) and R. N. Willson (*d*) record instructive cases of puerperal and uræmic convulsions in which relief was immediately obtained by lumbar puncture.

F. C. Eve (*e*) notes the case of a man with uræmic convulsions associated with total blindness. The convulsions were relieved by venesection, but the coma remained. Lumbar puncture was performed (fluid under high pressure). Next morning the man was quite conscious, and had recovered much of his sight.

Remarks.—The above cases are sufficient to show that marked relief may follow lumbar puncture in cases of uræmia. It is well known that uræmic convulsions and coma may disappear apart from such treatment, but the promptitude with which the improvement occurred was such as to leave no doubt in the minds of the observers that the relation was one of cause and effect. It is noteworthy also that in most of the cases the cerebro-spinal fluid did escape under considerable pressure. McVail states that in neither of his cases was there any increase, the fluid merely dropping away. Nevertheless, his two cases were strikingly successful, and he attributed the relief to the puncture, which obviously acts by diminishing the pressure of the cerebro-spinal fluid. It would be expected that the fluid would always issue from the needle with force, as, indeed, the above records show that it often does. But there are several points to consider. The needle is necessarily a fine one, and if its lumen became partially blocked in its passage through the tissues of the back, the fluid could only find its way out in drops. Another point is that there is at present no reliable instrument for measuring the tension of the spinal fluid. Eve's instrument, though very useful, only measures the height of fluid which finds its way out of the spinal space into a vertical glass tube connected with the needle. But this height of fluid is not a measure of the real pressure of the fluid in the cerebro-spinal space, for we have to consider that space as a practically closed-in cavity with walls of considerable rigidity. This cavity is always full of fluid or semi-fluid substance, and to force more fluid into such a space would necessitate great pressure, its normal contents being very little, if at all, compressible. Doubtless the ligaments of the spinal column would yield slightly, but scarcely to any great extent. It is therefore obvious that the addition of but a little fluid would very materially raise the pressure, and that this pressure would not be measured by the small amount of fluid which escaped into a vertical tube in connection with a needle in the space. To measure it, it would be necessary to puncture the space with a needle full of fluid and attached to a mercury manometer, the whole of the connecting tube as far as the mercury in the first limb being filled with fluid. Then, on inserting the needle into the space, the mercury in the proximal limb of the manometer would be depressed. The actual pressure would be ascertained by pouring mercury into the distal limb until the mercury meniscus in the proximate limb returned to the same position it occupied before the puncture was made. The difference in level between the two mercury menisci would be the measure of the real intraspinal pressure. Hürthle's manometer might also be used for the purpose, as the movement of fluid in and out of the tambour is exceedingly small. Another difficulty is that the cerebral pressure is relieved by removal of the *free* cerebro-spinal fluid. If, however, the pressure is mainly produced by a cerebral œdema, then unless a co-existent excess of free ventricular fluid was present, the removal of the little that would flow might not be sufficient to relieve the pressure materially. This fact might explain some of the cases in which relief is not obtained.

The manifestations of uræmia here considered which are so strikingly relieved by lumbar puncture are, as has been pointed out, so closely similar to the pressure symptoms produced in other conditions, such as cerebral tumour, cerebral hæmorrhage, &c., that uræmia has not infrequently been erroneously diagnosed as cerebral tumour, and the fact that the cerebro-spinal fluid is often under considerable pressure in these cases of uræmia, indicates that the underlying condition of increased intracranial tension must be responsible for the symptoms. Harvey Cushing also suggests this.

Uræmic Coma.—It has been pointed out that cerebral compression would produce a cerebral anæmia were it not that the blood pressure rises so as to keep just above the cerebral pressure and so maintains the cerebral circulation. But this compensatory process cannot go on indefinitely, and a certain point may be reached beyond which no amount of vasoconstriction and cardiac augmentation can maintain an adequate cerebral circulation. If this point is reached gradually and the volume of blood passing through the brain be slowly diminished, we should expect a comatose condition to develop, the last stage of cerebral compression with gradual respiratory failure; the high tension slow pulse of the early stage of compression changing into a soft, rapid pulse with the developing vasomotor failure. A concomitant toxic action on the brain is not denied; such may be present and aid in the production of the cerebral symptoms. But the anæmia alone should suffice to induce the coma.

Uræmic Convulsions.—Under the severe strain imposed upon it in working against a very high blood pressure the heart may fail rapidly in chronic nephritis. Should this occur, or should the vasomotor centre fail rapidly, it is clear that the cerebral circulation must fail equally rapidly when the intracranial tension is pathologically high. Instead of headache and somnolence, gradually deepening into coma, a more sudden unconsciousness would result, and if the failure in the circulation through the brain occur almost suddenly, convulsions would readily be produced. It is well known that sudden cerebral anæmia is a most potent cause of convulsions, as, for instance, in the well-known experiments of Kussmaul and Tenner, also after severe hæmorrhage, &c. The author has reported cases (*a*) in which the pulse stopped before the onset of ordinary epileptic fits, and has suggested that the cerebral anæmia so produced is sufficient in itself to account for the ordinary epileptic fit. It is of great interest to note that the onset of uræmic convulsions is, in fact, very apt

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(*a*) "Spinal Puncture in Uræmia."—*Brit. Med. Journ.*, Oct. 24th, 1903.

(*b*) "A Suggestion for the Treatment of Puerperal Convulsions by Spinal Subarachnoid Puncture."—*Brit. Med. Journ.*, May 14th, 1904.

(*c*) *Brit. Med. Journ.*, March 24th, 1906.

(*d*) *Journ. American Med. Assoc.*, Oct. 8th, 1904.

(*e*) "A Cerebro-spinal Manometer,"—*Lancet*, April 22nd, 1905, p. 1068.

(*a*) "Cessation of the Pulse during the onset of Epileptic Fits." *Lancet*, July 21st, 1906.

to be associated with marked evidences of circulatory failure.

According to Senator (*b*), "before the convulsions the pulse is often tense and slow, but during the attack it is small and accelerated and often irregular; as a rule, however, it cannot be counted accurately until after the attack, when it is also retarded in most cases." According to Strumpell (*c*), "the pulse is often very slow before the appearance of severe symptoms, sometimes 48 or 40, but it is almost always tense and hard. In chronic uræmia also a moderate slowness of the pulse is not infrequent. *When uræmic convulsions appear, however, the pulse usually becomes small and very frequent, especially in cases that terminate unfavourably.*" Willson's cases are of the greatest importance in this connection, especially as in his six cases of uræmic convulsions the convulsions terminated in every case on the withdrawal of the cerebro-spinal fluid; and it is to be noted that his best results were obtained in those cases in which the fluid spurted from the cannula, *i.e.*, in which the pressure within the cerebro-spinal space was greatest. *And this withdrawal of fluid by lowering the cerebral pressure would allow of an immediate return of blood to the brain.*

In cases of acute uræmia in acute nephritis it is well-known that an increase of blood pressure is common, and the cardiac failure may be more readily effected owing to the more toxic character of some of the diseases associated with acute nephritis, the poisons of the acute infections, such as scarlet fever, materially affecting the heart muscle. The heart would thereby be unable to respond to the vaso-constriction above described and the conservative rise of blood pressure would fail to develop.

This paper revives the old and discredited hypothesis of Traube, who considered that the cerebral anæmia was brought about through a compression of the blood vessels by œdema fluid. For this theory to rest on a sound basis it would have to be demonstrated that œdema does occur.

As regards this point, it is commonly stated that cerebral œdema is present or may be present in people dying of uræmia. Thus Senator, who though on the whole an opponent of the œdema theory, states (*d*), "It is quite true that œdema of the brain is frequently found in the bodies of those who have died of uræmia," but he adds that "the mere fact that this œdema of the brain is not constantly found proves that at most it is the cause in only part of the cases, providing, as Bartels believed, the œdema is not the result of the convulsions." The writer (Senator) does not think, however, that Bartel's view is correct; "for œdema of the brain is not always found even after the most violent convulsions produced by a great variety of poisons. But the fact that œdema of the brain is a frequent occurrence in uræmia does not in itself justify the conclusion that the two conditions have a casual connection, although it lends a certain modicum of probability to such a view. . . . It may be admitted that œdema of the brain in many cases is partly responsible for the development of uræmia, although other factors are probably present also. The writer is very much inclined to regard a circumscribed œdema of the brain as the cause of many focal manifestations, particularly amaurosis and hemiplegia, for which it would be difficult to find another explanation. . . . The irritability of the nervous centres is of the first importance, especially for the onset of a typical acute uræmic attack. . . . The immediate effect of the irritability appears to be a contraction of the small arteries, causing acute anæmia of the brain, which is a possible factor in the production of the attack, although it is probably not followed by cerebral œdema, as Traube asserts."

Senator, therefore, associates the attack with a cerebral anæmia whether produced by œdema or arterial spasm, but inasmuch as in many cases at least the intracranial tension is increased as shown by the spurting out of cerebro-spinal fluid on lumbar puncture, and by the extraordinary relief thereby effected, it is very probable that cerebral œdema with excess of cerebro-spinal fluid is commonly present in these cases. Such œdema would of necessity hinder the free access of blood to the brain, and the cerebral anæmia thereby produced would, in the absence of a compensating rise of the general blood pressure or on the failure of this compensating rise, account for many of the symptoms.

If this hypothesis be correct and if uræmic convulsions be due to a sudden cerebral anæmia as above suggested, considerable support is lent to the theory that epilepsy is produced by a sudden cerebral anæmia, for it is notorious that the convulsions of uræmia and of idiopathic epilepsy may be absolutely indistinguishable, and it is extremely probable that the factor underlying conditions so remarkable and so identical should be one and the same. The practical application that follows from the above is that lumbar puncture should be performed in cases of uræmia, whether coma, convulsions or merely severe headache be the predominant feature. The presence of a high blood pressure would be helpful as indicating the advisability of lumbar puncture.

On the above hypothesis of the origin of uræmia it is somewhat difficult to account for the material improvement that sometimes undoubtedly follows venesection, for inasmuch as venesection lowers the blood pressure, at any rate temporarily, it would act in opposition to the compensatory mechanism which maintains the cerebral circulation in the face of the high intracranial tension, and so should be a harmful rather than a beneficial procedure. It is possible, however, that the benefit which sometimes follows its employment is due to the relief of the failing heart with right sided distension. It would further facilitate the outflow of venous blood from the brain and so help to diminish intercranial tension. Moreover, a free venesection removes a material fraction of the total blood, and the present paper in no way disputes the presence of an abnormal and toxic blood in uræmic conditions.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

OPERATION FOR BRANCHIAL CYST OF NECK.—Mr. T. P. LEGG operated on a woman, æt. 37. She had noticed the lump for some months, and during the last few weeks it had got rapidly bigger. Practically no inconvenience had been caused by the swelling. She had no difficulty in swallowing or trouble with breathing. Beneath the right sterno-mastoid, on a level with the hyoid and upper part of the thyroid cartilage there was a large ovoid tumour, the long axis being placed horizontally. The tumour was as big as a duck's egg; it was quite smooth, movable on the deeper structures, and gave distinct fluctuation. The skin was normal, and no evidence of pressure effects on adjacent structures was found. Mr. Legg said that a diagnosis of branchial cyst was made: first, on account of the situation of the tumour beneath the sterno-mastoid and on the level of the hyoid bone; secondly, it was apparently a fluid swelling, and he might also mention here that the carotids were deep to the tumour. It was unlikely to be a tuberculous abscess due to disease of the glands, because there were no other evidences of the glands being affected, and it would be most unusual to find an abscess of this size due to tuberculous disease of one gland alone. The periphery of a tumour should always be carefully examined for nodules or gland-like lumps; if such were present they were a valuable aid in diagnosis. An aneurysm of the carotid could be excluded because the

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(*b*) Nothnagel's "Encyclopædia of Practical Medicine," American Edit., "Diseases of the Kidneys," p. 95.

(*c*) Strumpell, "Text Book of Medicine," Third American Edit., p. 600.

(*d*) "Diseases of the Kidneys," Nothnagel's "Encyclopædia," American Edit., p. 103 and iii.

swelling was fluid and did not pulsate. A transverse incision, four inches long, was made along the axis of the tumour, which was dissected out without much difficulty. The sterno-mastoid required partial division, as it and the tumour were closely adherent. The carotid sheath was detached, and at the upper end of the tumour a band-like process was tracked upwards and ligated before being divided. During the dissection, the cyst was ruptured, and opaque yellow liquid containing cholesterin cystals visible to the naked eye, escaped. The wall of the cyst was about one-eighth of an inch thick, and smooth internally; on the outer side it was rough. The sterno-mastoid was united by two or three mattrass sutures, and the wound closed, a drainage tube being put in at the posterior end of the incision. The fluid was examined at the end of the operation, and contained squamous epithelium, degenerated cells of various sorts, including leucocytes and cholesterin crystals. Mr. Legg remarked that as regards the operation, a transverse incision was best. It gives plenty of room, and if made slightly curved, a flap can be dissected up in order to increase the exposure of the deeper parts. Moreover, the scar becomes practically invisible in the course of time. In suturing these incisions, it was always advisable, he considered, to put in two or three stitches which unite the cut edges of the platysma and deep fascia. By doing so, the margins of the skin incision were closely approximated, and the sutures in the skin can be removed in four or five days. Thus very often the stitch marks are invisible. The removal of these cysts, he pointed out, was not always as easy as in this case. They were always in close contact with the great vessels and nerves of the neck, and sometimes the cyst passed between these structures. Hence, in separating the deeper parts, the surgeon has to keep close to the cyst, and see exactly what he is doing. The band-like process required tracing as far as possible and ligating. It contained the remains of a branchial cleft from which the cyst was derived by dilation of an unobliterated portion. Which cleft this particular cyst was derived from was not very certain, because it was impossible to make out the exact relations of the cyst to the vessels and nerves. They were not very rare tumours. During the last two or three years there had been three or four cases in the hospital. One patient was a child, æt. about 13, and there had been two other young adult patients. Subsequently a microscopic examination of the cyst wall in the present case showed the lining epithelium to be squamous, thus confirming the diagnosis.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 30th 1907.

The Treatment of Syphilis.

In treating syphilitic patients, certain restrictions should be observed in the employment of the mercurial treatment. Of these restrictions, some depend on the form to be prescribed, in which account should be taken of the extreme susceptibility of certain organs such as the stomach, intestines, bladder, while others concern the dose, which should be proportioned to the resistance of the subject, and to the permeability, more or less diminished, of the emunctories.

The best form of application, says Prof. Belugon, is hypodermic injection of the soluble salts. The intramuscular introduction of the drug is the most exact and precise method, which also allows supervision of the doses employed. The gastro-intestinal disorders which frequently follow the use of pills or mixtures expose neuropathic patients to danger.

As to mercurial ointment frictions, they have the fault of being difficult to control as to the dosage. Sometimes the patient will use too much, at others the quantity will be insufficient.

Insoluble injections and particularly those of calomel should be reserved for extreme cases where rapidity is necessary, in ocular syphilis, etc., and in tabetic patients showing symptoms of cerebral disturbance, persistent vertigo, epileptic attacks, aphasia, and hemiplegia.

Of the soluble salts, benzoate or bichloride of mercury are the most easily absorbed.

The cure should be divided into three or four series of twelve injections each with a corresponding interval of rest.

Vegetations of the Genital Organs.

An easy method of treating isolated and pedunculated vegetations is to place on the papilloma a small quantity of resorcin by means of a moistened hair pencil, and cover with a piece of gauze. The application is renewed each day until the vegetation is dried up.

Where the vegetations are numerous and sessile the following mixture is painted over them.

Resorcin	drachms 2.
Collodion	ounce 1.

Two or three applications are sufficient. To avoid a return of these troublesome excrescences, the patient should bathe the parts in a solution of resorcin, ½ per cent. and apply the following powder:—

Carbonate of zinc	drachms 2.
Sub-nitrate of Bismuth ..	drachms 2.
Resorcin	drachm ½.
Talc powder	ounces 3.

Infantile Eczema.

At the last meeting of the Academie de Medecine, M. Variot, of the Children's Hospital, said that infantile eczema was rapidly and favourably influenced by subcutaneous injections of isotonic sea-water. In three fourths of the cases the treatment was entirely successful. After the first two or three injections the eczema became inflamed, with abundant weeping, after which an improvement set in, the scales became detached, and a cure followed. Sometimes there is no reaction, and in such cases the improvement is almost instantaneous, and the lesions begin to pale the following day. One ounce of this sea-water is injected every two or three days. According to M. Variot, no other treatment gave such favourable results.

GERMANY.

Berlin, June 30th. 1907.

Extraordinary Results from a Dagger Thrust.

At the Medizinische Gesellschalft Hr. H. Hirschfeld showed a young man who, several months before, had received a dagger thrust in the right cheek below the malar bone. Immediately afterwards he could not speak, had a difficulty in swallowing, and the right half of his face drooped. The wound healed slowly, as a salivary fistula formed in consequence of a wound of the parotid. Now the following changes were noted:—The right eyelid and pupil were narrowed, the right half of the face did not perspire, the tongue lay obliquely, the whole right half of the cavity of the mouth was without sensation; the larynx deviated to the right on swallowing, the right vocal cord was immobile in the position of that of the dead body, the right side of the fauces and larynx had no sensation, so that there was frequent swallowing. Pressure on a certain spot of the right side of the neck set up coughing, the right sterno-cleido-mastoid and platysma were atrophied. It was a case therefore of injury of the seventh, ninth, tenth, eleventh and twelfth cerebral nerves, as well as of the sympathic at the base of the skull. Whether it was possible to unite the nerves by suture he had not decided.

At the Congress of the German Society for Orthopædic Surgery, Hr. Karch, Aachen, described his misfortunes and successes in

Transplantation of Tendons (300 Joints).

He put forward the following conclusions:—The positive success of the operation stands and falls (1) with the exact indication; (2) with the operative technique; (3) with the technique as regards bandaging; (4) with the quality of the after-treatment. Flaccid paralysis affords the most frequent indication for operation, and shows the finest results. The limits of the indication are very wide. If an extensive flaccid paralysis has existed for more than ten years transplantation only rarely shows good results. It is better then as regards the lower extremities to perform arthro, teno, or fasciodesis. Caution is required in the winter time if chilblains are present. Transplantation in spastic paralysis requires much experience in knowing how far to go; an excess in yielding power never leads to an improvement of the condition. Simple plastic lengthening is often sufficient. In complicated spastic paralysis of the upper extremities the results obtained by operation are not always satisfactory. It is hopeful that treatment with implantation of the nerve will give better result. Peripheral paralysis and loss of power from traumatism are satisfactory objects of treatment. Contractions with flexion are efficiently met by exact transplantation. Advancing cerebro-spinal affections should never be treated by transplantation.

2. The plan of operation must be simple. Periosteal transplantation is to be preferred; that of tendon to tendon along with this is proper, and is sometimes the only way to success. Functional independence is best assured by periosteal implantation. In transplantation from tendon to tendon some of the associated muscle should be used to give power. Transplantation of bone and the boring of bony canals must be avoided. Button-hole implantation is the best, and sublimate silk for the suture material. Of course, the limb must be put right, and if necessary the tendon shortened before the implantation is done. On the dorsum of the foot, in order to avoid pressure gangrene any tense tendon bridges are to be removed from the periosteum by means of a silk loop, so that they run through a sort of tunnel of silk. For shortening, folds should be made and fixed; for lengthening, step or surface incisions. Very poor tendons may be shortened if they are first sutured to the tendon of an associated muscle that is in function. "*Deshabiller Pierre pour revêtir Paul*" is allowable under some circumstances, when an important function can be gained by the sacrifice of one less important. Stitch abscesses were rare and did no harm. Suppuration is very rare, and does not prejudice the result. They were to be avoided by immaculate asepsis, arrest of bleeding, and exact skin suture. Flat shaped muscles were not to be transplanted.

3. At the close of the operation the joint must be placed in the desired position; dressing was not advisable during the hardening of the covering. The dressing must be cut open if when the rubber bandage was removed the circulation did not return promptly. The dressing should remain on for eight weeks. There was no change of dressing when the skin suture was of silk and recovery normal.

4. The after-treatment is important, for a permanent success conscientious massage must be carried out. Further, active, passive and later, resistance movements would be necessary, or the wearing of a portable apparatus, as well as the employment of physical curative measures.

Transplantation of tendons was the most important novelty in the treatment of paralysis. Along with this, and sometimes taking its place, would be the still incompleted method of nerve grafting. Both were justifiable; for the majority of cases tendon transplantation would remain sovereign.

AUSTRIA.

Vienna, June 30th, 1907.

Cataracta Complicata.

KONIGSTEIN showed a male patient to the "Gesellschaft" with an old standing cataract which he considered inadvisable to operate on, as the sensation of light was probably lost and no good would result. This case was before the members six years ago, when the same opinion was formed.

The present condition is rather peculiar. The anterior chamber is filled with a mass that glistens and glitters like gold when light is thrown on it. He considered this due to granules and scales of cholesterin which had become deposited in the membrani Descemet lining the interior of the cornea, or it may be blood colouring deposited in the cornea itself. From this it would seem that the capsule of the lens had burst, exuding the contents which have taken on a retrogressive metamorphosis forming cholesterin, or perhaps the effused blood has undergone the change and produced this phenomenal body.

Scapular Rhonchus.

Lotheissen showed a peculiar case of loud crackling under the right scapula, which could be heard when standing at a considerable distance from the patient. There was no tuberculosis, or muscular atrophy in the serratus muscle, to account for the strange phenomenon. He considered the change to be due to a dry proliferating bursa which could not be cured without operation.

Cystic Widening of Ureters.

Kapsammer next showed a case that had been diagnosed by the cystoscope as a morbid condition of the urinary apparatus. Three weeks ago he performed the abdominal section and found both ureters distended into two cysts, which apparently were congenital defects, and not morbid as at first presumed. This wide condition extended far up the ureters, which were healthy and otherwise in good condition. He pointed to this as an example of an unavoidable error.

Pes Varus.

Semeleder reported the success he has met with by his method already described of treating talipes varus in the paralytic form which many are sceptical about. He exhibited photos of sixty cases before and after treatment, which are convincing of success, whatever the method may be by which he had accomplished it. The idea carried out in his apparatus is to prevent the antagonism of the healthy muscles distorting the member by tearing the paralytic muscle too far and destroying its functional activity, which he considers the sole cause of the anatomical deformity. If the paralysed muscles are physiologically checked, atrophy commences, while the strong muscles with the weight of the body complete the destruction. His object, therefore, is to place the action on the paralysed muscle and leave the strong muscle to atrophy.

Photos of two cases presented were of considerable interest, as the original photos and the present condition were marvellous contrasts.

Alberle challenged the method as having a special advantage, for he has treated similar cases with a wedge ½ to 1 centimetre with perfect success, and they never required to put the patient to bed. This destroyed Semeleder's assurance that his boot had any influence in strengthening the muscles of the leg. The weight of the body is not all that is to be considered for this correction, or Beely's apparatus would be quite sufficient. If the talipes is not severe, the least painful and more effectual method is the manual correction which can be done by the mother or the nurse. Semeleder replied that many of the other apparatuses required the patient to remain in bed, but his did not, as the patient could move about with advantage; with his apparatus the legs would be corrected in two weeks, with other forms the patient may wear them years without any visible improvement.

Physiological and Pathological Circulation.

Benedikt described the changes in the circulation, remarking that cramp in both of the large crural arteries may occur at the same time, thus showing a homonymous pulse as if a normal condition existed. If the carotid pulse is greater on one side than the other, so is the radial pulse of the former less than the latter, *i.e.*, the sides are inverted. This is not a constant anatomical fact, but is usual. Basch found different pressures in homonymous vessels. The prodromal symptoms of apoplexy can be detected by any departure from this anatomical relationship.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE ASSAULT ON DR. CARSWELL, GLASGOW.—Purvis, who assailed Dr. Carswell in the streets of Glasgow with a revolver on April 16th last, was brought before Sheriff Glegg on June 22nd. The Procurators Fiscal stated that he had been examined by experts in lunacy on several occasions since his incarceration, and had been certified as of unsound mind, and was therefore unable to plead to the indictment. An agent who appeared for Purvis asked the Sheriff to take a plea of not guilty. The Sheriff, however, following the precedent in the Cumnock poisoning case, reserved the matter for the consideration of the High Court.

EDINBURGH ROYAL INFIRMARY.—At their meeting on June 24th, the managers appointed Dr. Douglas Chalmers Watson, F.R.C.P., to be an assistant physician, and Mr. William J. Stuart to be an assistant surgeon to the Institution. There were a number of candidates for both posts.

SIDLAW SANATORIUM, DUNDEE.—During the year, 115 patients have been treated. Of the discharges, numbering 79, 18 were unsuitable cases; of the 61 remaining, the disease was arrested in 34, markedly improved in 24, stationary in 3. The medical superintendent has kept in touch with the patients who have left, and reports that at the end of the year 90 per cent. of the arrested cases were in good health, and 70 per cent. were at work. Of similar cases discharged last year, 85 per cent. continue well. Such results are highly satisfactory. The sanatorium is kept up by public subscription, a small sum being received from the patients. The cost per patient is 38s. per week.

THE LATE DR. HOWDEN, HADDINGTON.—The death took place on the 25th ult. of Robert Howden, M.B., who represented a family of East Lothian doctors which had been connected with the county for nearly a century. He was the grandson of Dr. Thomas Howden, who was a partner of Dr. Welsh, father of Mrs. Carlyle. His own father, Dr. Thomas Howden, died in 1900 at the age of 89, and a brother, Dr. Thomas Howden (*tertius*), died in 1878. Dr. Robert, who fell a victim to pneumonia, held a number of local medical appointments, and had an extensive practice. He is survived by a widow and two children.

LETTERS TO THE EDITOR.

LIVINGSTONE COLLEGE AND MEDICAL MISSIONARIES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I desire to thank you for your kind reference to Livingstone College in your last issue, but hope you will permit me to offer some explanation of the system which is adopted at this College.

Let me say in the first place that I agree with you most fully that it is in the highest degree desirable that men going abroad as missionaries should have the best medical qualifications. The Church Missionary Society, of which I was formerly a medical missionary, and am now physician, has sent to the Mission Field a number of medical missionaries of the best type, many of them possessing exceptional scientific qualifications. This is as it should be, and I desire to see the list of medical missionaries largely increased.

There is, however, another problem wholly different from this which has to be considered. Many missionaries are called upon to work in isolated stations far from qualified medical or surgical help. At any moment they or their fellow missionaries or families may be struck down by some rapidly fatal illness or accident, which can have but one issue unless they possess such medical knowledge as would enable them to identify and cope with these ailments. Livingstone College men have been able in many cases to preserve their own lives and that of other Europeans, and I have little doubt that scores of lives have been thus saved.

Again, men so placed often find themselves amongst ignorant natives who suffer unspeakable tortures from neglected wounds, abscesses and ulcers, whose sufferings are intensified by the methods of so-called witch-doctors. Common humanity will not allow a civilised man, much less a Christian man, to see such things, which simple aid can relieve, and refuse to render that aid. Yet if these things are to be done training must be given. Previous to the existence of Livingstone College men attended the ordinary hospitals and picked up what knowledge they could, and there was great danger that they might undertake treatment which they were utterly unfitted to carry out. At Livingstone College students are not only taught carefully what they may do, but what they must not attempt, and we have never heard of any serious mistake being made. Besides this the students sign a declaration that they will not call themselves medical missionaries or assume the position of qualified medical men. What more can we do? What less can we do? You in common with the other chief organs of the medical profession have most generously supported us in the past. I venture to hope that we may rely upon your continued support.

I am, Sir, yours truly,
CHARLES F. HARFORD, M.D.,
Principal of Livingstone College.

Leyton, June 24th, 1907.

THE EXCLUSION OF SCOTCH AND IRISH DIPLOMATES FROM THE MAJORITY OF LONDON HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The outspoken letter in your issue of June 19th deserves careful attention. The majority of the large English hospitals, both in London and the provinces, exclude both Irish and Scotch medical diplomates from their honorary medical staffs. This disqualification has been placed on the laws of hospitals in past times when possibly there were not so many qualified medical men educated in Scotch and Irish colleges and universities. Anyway, it constitutes a standing injustice to many honourable and highly qualified men.

What does the boycott mean? A very slight analysis will, I think, show that the matter is simply one of class privilege. It is obviously advantageous to holders of English diplomas and degrees to have a monopoly of these valuable professional posts. It is equally advantageous to the colleges and universities that grant the special qualifications whereby alone the monopolist appointments may be secured. But what about the men and the colleges that are shouldered out by the monopolists?

If the public were fully informed of the facts of the case, it is hardly likely that this injustice would long be permitted to continue. A considerable proportion of the governors of hospitals are attended medically by Scotch and Irish diplomates and graduates. What would governors say if the men who are considered good enough to attend themselves are not permitted to attend hospital patients?

Let us, at any rate, have the full light of day upon the situation. If the English colleges can show they have good ground for maintaining their monopoly, by all means let them keep their privilege; otherwise, let us have some sort of equality of opportunity afforded to all duly qualified medical practitioners within the United Kingdom.—Yours faithfully,

A SCOTCH F.R.C.S.

Manchester, July 1, 1907.

THE council of the London School of Medicine for Women have received from Mrs. Godfrey Walker, of Conisborough Priory, Yorkshire, the munificient gift of £20,000 in aid of the endowment of the school.

THE TEACHING OF PHYSIOLOGY.

To the Editor of The Medical Press and Circular.

Sir,—With regard to the admirable letter from your Dublin correspondent I trust the matter will be discussed fully in your columns. It has always seemed to me personally that it is sheer waste of time to demand of medical students a knowledge (!) of advanced physiological experiment and theory. The only possible excuse for making such a demand appears to be the intellectual training of the student, but that could surely be obtained by other methods more likely to help him in the after battle of professional life.

I am, Sir, yours truly,
Duns Scotus.

Colwyn Bay, July 1st, 1907.

OBITUARY.

SIR WILLIAM TENNANT GAIRDNER.

Sir W. T. Gairdner, K.C.B., LL.D., M.D., died on Friday last at the advanced age of 82. He had been laid aside from active work through failing eyesight for a number of years past, and for several years had suffered from cardiac disease. His death, however, was sudden in the extreme. Up till a day or two ago he was able to take his usual drives into the country, and on the morning of the day of his death he was able to receive an old friend who had come into Edinburgh to attend the Old Residents' Dinner, and to send by him his apologies and regrets for inability to be present at that gathering. Before the message, however, could be conveyed, Sir William had passed away. Deceased was born in 1824, in Edinburgh, his father being the late Dr. John Gairdner, a president of the Royal College of Surgeons, Edinburgh. He graduated M.D. in 1845, and for his thesis, which was on the subject of "Death," he was awarded a gold medal. After graduating, he travelled abroad as physician to the Earl and Countess of Beverley, and returned in about a year's time to Edinburgh, where, at the early age of 24, he was appointed pathologist to the Royal Infirmary in succession to Hughes Bennet. Soon after this, in 1853, he began to lecture on the Practice of Physic in the extramural school, and continued his class until his appointment to the Chair of Medicine in the University of Glasgow in 1862. Sir William Gairdner's interests at that time were much directed towards matters of sanitation and public health. In the year of his election to the Glasgow professorship, he published an important work on "Public Health in Relation to Air and Water," which was a record of the first course of lectures on sanitation ever delivered in Scotland. This attracted the attention of the municipal health authorities to Dr. Gairdner, and the late Mr. John Ure (afterwards Provost of Glasgow) entered into negotiations with the writer with the object of securing his assistance in carrying out a scheme for establishing a health department in the city. After some demur, lest the proposed work should interfere with his University duties, the Professor accepted an appointment as Medical Officer of Health for Glasgow. He was the first occupant of that office, and held the post for nine years from 1863. During this time he successfully combated several severe epidemics. These, along with a threatened outbreak of cholera in 1866, led the new Medical Officer to make a systematic investigation of the conditions of housing in the slums, and he was sent to Paris to report on the improvements then being carried out by Napoleon III. in the French capital. These investigations, added to his previous experience of conditions in Glasgow, proved of valuable assistance in connection with the first Municipal Improvement Act, which revolutionized the sanitation of the city. Professor Gairdner occupied the Chair of Medicine in Glasgow for nearly forty years. He resigned in 1900, because of failing vision, which prevented his keeping abreast of medical literature, and also debarred him from microscopic work and bacteriological investigation. After Lord Kelvin's retirement, Gairdner became "Father of the Senatus." He was greatly esteemed as a teacher, and as a clinician he justly enjoyed the highest reputation. He was the recipient of many professional honours: Honorary Physician to the King in Scotland, LL.D.Edin., M.D. (honoris causa) Dublin, Honorary Fellow of the Royal College of Physicians of Ireland. He was also a Fellow of the Royal Society, of the Royal Medical and Chirurgical Society, and an honorary member of many other learned bodies. He was President of the British Medical Association on the occasion of its visit to Glasgow in 1888, and he also filled the position of President of the Royal College of Physicians of Edinburgh. He was made a K.C.B. in 1898. Sir William Gairdner's medical writings were numerous. He was greatly interested in diseases of the heart, and his graphic methods of recording physical signs are well known. He published a volume on "Clinical Medicine" in 1862, and delivered the Morison Lectures on "Insanity" in 1879. "The Physician as a Naturalist" came from his pen in 1889. Sir William Gairdner was a man of varied talent; it is said of him that he could have filled almost any chair in the University. He never lost his interest in affairs medical, and even his own last illness afforded him matter for professional study. He married in 1870, and is survived by his widow, four sons, and three daughters.

JOHN M. HARRISON, M.R.C.S., L.S.A.

It is with deep regret we announce the death of Audlem's oldest medical practitioner, Mr. John Mare Harrison, M.R.C.S., on June 18th, at his residence, after several months' illness. The deceased gentleman was born at Leek, Staffordshire, on November 6th, 1817, and was the youngest son of the late Dr. Gallimore Harrison. Previous to going to Audlem, Dr. Harrison practised for several years in Burslem. His practice in Audlem extended 50 years, and during that time he was a kind friend to the poor, and highly esteemed by all. He was a staunch Churchman, an ardent supporter of the schools, and always lent a helping hand to further any good cause. Much sympathy is felt for the two daughters, Mrs. Jackson and Mrs. Greaves.

WILLIAM SUGDEN WRIGLEY, M.B., Ch.B. Vict.

We regret to announce the death on June 22nd, of Dr. W. S. Wrigley, of Rawtenstall, at the age of 27. Two years ago he took up practice in Nelson, and he had only recently been married. He was educated at Owen's College, and graduated M.B., Ch.B. in the Victoria University, with first-class honours, in 1902, and he later served as House Surgeon in the Manchester Royal Infirmary.

SPECIAL ARTICLE.

MEETING OF THE ROYAL SANITARY INSTITUTE.

The Royal Sanitary Institute held its annual meeting last week in Trinity College, Dublin, with Sir Charles Cameron as President.

In his inaugural address the President detailed the development of sanitary administration in Dublin during the past half-century. Thirty-seven out of every 100 families in Dublin occupied each a single room. In many English towns not 10 per cent. of the families were occupiers each of a single room. The poverty of a large proportion of the people was shown by the fact that whilst about 16 or 18 per cent. of deaths in English towns occurred in workhouses, hospitals, and other institutions, more than 40 per cent. of the deaths in the City of Dublin take place in these institutions. It was not fair to compare a city which, as in the case of Dublin, contained an abnormally large poor population, with cities like London, in which there were higher standards of wealth and comfort. In 1906 the expenditure of the Public Health Committee amounted to £15,593. A large proportion of the expenditure was in relation to the maintenance of fever patients, payment for notifications of infectious diseases, fees to the registrars of Cemetery Boards, working the Act relating to the street trading of children, contributions towards the maintenance of open spaces, proportion of law agents' and accountants' expenses, expenses in connection with the Contagious Diseases (Animals) Acts, and in providing dwellings for the working classes. The Corporation had expended £485,000 in clearing unhealthy areas, and a very large sum in the erection of baths, wash-houses, refuse destructors, abattoirs, &c. The Corporation of Dublin had expended £345,000 in providing dwellings for the working classes, and a large sum in the erection of baths and wash-houses, abattoirs, and a disinfecting house refuge for persons whose residences were undergoing disinfection or who had been in contact with cases of infectious disease. A sum considerably over half a million had been expended in main drainage works, designed to free the River Liffey from pollution and to prevent the blocking of the street sewers.

The various forms of tuberculosis caused a large proportion of the deaths which occurred in Dublin. In 1906 there were 937 deaths from tuberculosis of the lungs, or in the ratio of 3.15 per 1,000 of the population. The deaths from all forms of tuberculosis numbered 1,386, or in the ratio of 4.71 per 1,000 persons living. It was remarkable that whilst all other diseases, of which the *materies morbi* consisted of pathogenic micro-organisms, had greatly declined in Dublin, tuberculosis, which belonged to that class, continued unabated. The three great problems demanding solution are: How was the terrible mortality of children to be lessened? How were the ravages of tuberculosis to be minimised? How were the very poor to be provided with healthy dwellings?

The paper was discussed by Mr. H. O. Searles Wood and Sir John Moore.

On the 26th, the President read a paper on "Sanitary Science and Preventive Medicine."

Mr. C. L. Birmingham, M.D., denied that they in Ireland were in the rear as regards the laws of public health. He denied also that the sanitary laws in some places were practically a dead letter. The sanitary laws were being carried out instinctively by the people. He had never known a people so ready to follow advice on sanitary matters, but they would not be driven. He had no difficulty in establishing a system of voluntary notification of tuberculosis. The vaccination laws were carried out with the greatest promptitude. So great was the burden thrown on the medical officers that they were bound to close their eyes to a great deal. He was obliged absolutely to ignore the Home Office queries.

Among those who took part in the discussion were Drs. Magennis, Agnew, and Flinn, Mr. S. G. Moore, Mr. J. Lindsay, and the Registrar-General for Ireland.

The following resolution was passed:—"That this Conference is of opinion that it would be desirable to have county medical officers of health with a sufficient staff of qualified sanitary inspectors appointed for Ireland, and that the Council of the Royal Sanitary Institute be requested to take steps to urge this opinion upon the consideration of the Government."

Dr. McWeeney read a paper on "The Role of Sanatoria in Checking Tuberculosis," which was discussed by Sir Charles Cameron, Drs. Hanaford, Antony Roche, and Willoughby, and Mr. E. T. Hall.

On June 27th, discussions took place on "Housing of the Working Classes," and "Sewage Disposal," the subjects being introduced by Mr. P. C. Cowan and Mr. W. Kaye Parry respectively.

On the 28th, Sir John Moore read a paper on "The Climatology of Ireland in Relation to Public Health," in which he maintained that the climate of Ireland, generally, is the most temperate in the world, and the most conducive to health and longevity, and with efficient sanitary organisation and cleanliness in the homes, the island would rank as one of the healthiest countries on earth.

Sir Charles Cameron said there were very few climates, on the whole, superior to that of Ireland. The principal feature was its equability. There was only about ten degrees difference between the mean winter and summer temperatures. A low death-rate was usually co-incident with a cool summer and a mild winter. He dreaded a hot summer and a cold winter, for there was no greater fallacy than that a green Yule makes a fat churchyard.

Mr. Rideal, D.Sc., F.I.C., read a paper on "Disinfection Considered from a Medical, Chemical, and Bacteriological Standpoint." Both he and Mr. A. E. Moore, M.B., B.Ch., R.U.I., Queen's College, Cork, agreed on the necessity for the standardisation of commercial disinfectants; and Dr. S. G. Moore, M.D., Medical Officer of Health, Huddersfield, said that the great majority of the disinfectants sold under fancy names, and, of course, at fancy prices, were, to a large extent, ineffective. Ordinary daylight, fresh air, high temperature secured by means of steam, and soap and water were agencies which without any chemicals at all were absolute and complete disinfectants.

The Registrar-General for Ireland (Mr. Matheson) quoted some interesting statistics showing the relation of earth temperature to deaths from diarrhœal diseases, and also spoke of the close relation between the decrease of temperature and increase of mortality from diseases of the respiratory organs.

The Chairman said if the natural agencies of disinfection, such as sunlight, heat, &c., were extensively utilised, tuberculosis would have disappeared from the country in fifty years.

At the conclusion of the proceedings votes of thanks were passed to the Lord Lieutenant and the Countess of Aberdeen, to the Provost and Fellows of Trinity College, to the Lord Mayor, to the directors of Guinness's Brewery, the trustees of the Iveagh Trust, to the Dean of St. Patrick's Cathedral, to Colonel Plunkett, Director of the Science and Art Museum, Alderman Cotton, and others, to Surgeon-Colonel Dr. Edgar Flinn, and Mr. W. Kaye Parry, and also to Sir Charles Cameron.

REVIEWS OF BOOKS.

TEXT-BOOK OF PATHOLOGY. (*a*)

The value of this text-book is well shown by the fact that in the nine years since it first appeared, five editions have been issued. The author has succeeded in introducing many new facts, and in revising the text in many instances without materially adding to the size of the book—a matter of some importance in a volume of this character. The chapters on "Inflammation and Immunity," have been carefully revised, but the author's determination to avoid any lengthy details of pathologic physiology, while doubtless unavoidable, necessitates the omission of many important researches. This particularly refers to the recent experimental work on the pathology of cancer, which hardly receives adequate treatment in this work. Many of the chapters are excellent, particularly that on "Diseases Due to Bacteria," that on "Animal Parasites," which has been largely re-written, and the chapter on "Urines." As is perhaps unavoidable, one finds unexpected omissions. For instance, there is no mention of the pyloric stenosis of infants, the pathology of which has been so much in question, and little is said of some other important subjects, *e.g.*, carcinoma of the kidney is dismissed in a few lines, gastric carcinoma is discussed very shortly, and "hernia" and "peritonitis" (particularly the latter in the pathology of which much work has been done of late) are hardly up to the level of much of the rest. An admirable appendix containing details of pathological and bacteriological laboratory work is introduced, and will be found of great value. The book is well got-up and printed, although the proof-reader has passed many misprints in the article on "Endothelioma." Many illustrations and seven full-page colour plates add to the value of the edition, though it is to be hoped that such an illustration as that of "syphilitic cirrhosis of the liver" (page 611) may be eliminated in future editions

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(*a*) "Text-book of Pathology." By Alfred Stengel, M.D. Fifth Edition. Pp. 935. Philadelphia: W. B. Saunders and Co. 1906.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT OBSTETRICAL LITERATURE.

Chorea During Pregnancy.—Shaw (*Journ. Obst. and Gynæ.*, 1907).—This is a report of eleven cases of chorea of pregnancy. The first two cases were treated on traditional lines with unsatisfactory results. It was then decided to try anti-toxin treatment, by which patients were put on a milk diet and elimination increased. In nine cases so treated the best results were secured. The idea underlying the experiment was that the toxæmia of pregnancy lowers the resistance of the nervous system, and puts it in a state of heightened irritability, so that it responds to stimulæ, chemical and emotional, &c., which would not otherwise produce any result perceptible by ordinary clinical methods of observation. Based on this hypothesis, the treatment aims at (1) removing the pre-disposing cause; (2) removing the determining cause; (3) treating the symptoms, if necessary. The author's conclusions are: (1) The chorea of pregnancy, like other choreas is due to a toxin which appears to be identical with, or closely to resemble, that of acute rheumatism; (2) it affects human subjects under two circumstances, both of these being characterised by instability or irritability of the nervous system, namely, childhood and pregnancy; (3) the cause of the instability or irritability of the nervous system in pregnancy bringing it down to the level of childhood, is the toxæmia of pregnancy; (4) in the chorea of pregnancy, therefore, it is more important to remove the pre-disposing cause than to apply merely symptomatic treatment; (5) the treatment must be eliminative as in the other toxæmias of pregnancy; (6) the pregnancy should not be arrested, as a rule, as this is generally unnecessary and harmful to the patient, as well as to the child. F.

Puerperal Peritonitis Treated by Abdominal Section.—GORDON (*Journ. of Obstet. and Gynæ.*, June, 1907).—This is a report of ten cases treated in the Monsell Fever Hospital, Manchester. All the patients were in a very critical condition when admitted to hospital and operated on, and many were regarded as being in a hopeless state. Of the ten cases four died and six recovered. The conditions found on opening the abdomen consisted of general peritoneal infection, discharging pus tubes and abscesses of ovary or uterine wall, abscesses in Douglas' space, cellulitis, and decomposing placental remains inside uterus, most of these conditions were present in each case; the discharging pus tubes being common to all. Cultures made from the peritoneal fluid showed streptococci alone in four cases, streptococci with bacilli coli communes in three, streptococci and gonococci in two, and in one case cultures taken from the blood during life showed streptococci only, while those from the uterus gave streptococci, bacilli coli and staphylococci. In only one case was flushing of the peritoneal cavity resorted to, but in this case the writer attributes the patient's recovery to it. However, he is of opinion that, as a rule, it is best not to flush or even sponge the peritoneal cavity at all, but to rely rather on free drainage at the most dependent part, with subsequent propping up of the patient in a sitting position, and the subcutaneous injection of saline solution with or without anti-streptococcic serum and adrenalin. Calomel is almost invariably administered on the second or third day. Cases where placental masses remained in the uterus, were curetted with a large sharp curette, swabbed with pure izal, or corrosive sublimate solution and packed with gauze. F.

The Treatment of Post-partum Hæmorrhage, with a New Method of Hæmostasis.—Stowe (*Surg., Gyn., and Obstet.*, June, 1907).—After reviewing the prophylaxis of post-partum hæmorrhage, the writer says that in cases where massage of the uterus and expulsion of clots with emptying of a distended bladder fail to control hæmorrhage, and where from atony of the uterus, the organ lies in the pelvis like an empty sac, with its walls soft and offering no resistance to the hand, he has with great satisfaction tried a new method of hæmostasis. As the patient is bleeding profusely at the time something must be done immediately so he grasps and firmly kneads the fundus with one hand at the same time pressing it down into the inlet. The other hand, encased in a sterile glove, is passed into the vagina up to the cervix, the fingers seizing as much of the cervix and lower uterine segment as possible. The hand is then forced far into Bandels ring until the fundus is reached. The internal hand remains thus outside the uterine cavity throughout the operation. If sufficient pressure be used the internal hand can be forced well into the fundus and past the contraction ring, pushing the cervix and lower uterine segment before it against the walls of the fundus. This obliterates the cavity of the uterus and brings direct pressure and compression to bear against the sinuses and open vessels. The position of the internal hand or fist in the fundus, yet outside the uterus, has a marked effect in stimulating contraction, especially when aided by brisk massage and by inverting the lower portion of the uterus into the upper direct pressure is brought to bear by the hand against the uterine arteries, and the supply of blood is in a great measure shut off. If arrest of hæmorrhage is in great part obtained, and the uterus contracts poorly, an intra-uterine douche at 115 F. is given. If the bi-manual compression and the douche produce only temporary hæmostasis further delay is dangerous and recourse should be had to the utero-vaginal tamponnade. F.

Asepsis during Abdominal Operations.—Fritsch, at the meeting of the German Gynæcological Congress at Dresden (*Zentralblatt für Gyn*, 1907, No. 25) said among other remarks on this subject that the efforts to produce asepsis through the course of an operation may be divided into the following parts:—(1) The sterility of the hands; (2) The sterility of the field of operation; (3) The prevention of pollution during the operation. The importance of preserving the hands has led the author to give up the hot-water—alcohol-sublimate disinfection for the soap—spirit disinfection of v. Mikulicz. Rubber gloves are necessary. Further it is most important whenever an unclean wound is touched or during a rectal examination or vaginal exploration when there is discharge, for example, carcinoma, that rubber gloves should always be worn. Operating with perforated or torn gloves is careless and irrational. Repeated rinsing of the hands during operation in sublimate and sterilised water is to be recommended. As regards the asepsis of the field of operation we have to deal with three regions, (*a*) The skin of the abdominal wall; (*b*) the vagina, and (*c*) the vulva with the anus. For this also the soap-spirit disinfection is admissible. The speaker has now adopted Döderlein's proceeding, not because his results formerly were bad, but because one is ready sooner without allowing the patient to become cold. The abdomen is first rubbed over with benzine, then with a gauze wipe, soaked in tincture of iodine, and after this has dried it is smeared evenly all over with a solution of rubber Döderlein's "Gaudanin," with the apparatus which has been constructed for this purpose. When the rubber is powdered over with sterile chalk the preparation is finished. The bacteria deep in the skin are best overcome with the tincture of iodine, while they are kept away from the wound by the rubber membrane. Further, in order that the tissues may preserve their vitality and their power of re-acting to infection, it is necessary that they should be protected; therefore the operating should be quick and skilful. The speaker also recommended Stœckel's speculum for protection of the abdominal wound. The finger should be employed for the separation of intestinal adhesions, adherent cysts and tumours. The intestines should never be allowed to come outside the abdominal cavity. This is easily prevented in the pelvis high position by putting in a large compress. This absorbs blood and even pus so well that after its removal wiping out the cavity may be omitted. To prevent ileus and adhesions it is necessary to cover over every raw surface in the peritoneal cavity. Pfassuenstiel's incision combines all the advantages of ventral laparotomy with the advantages of the vaginal operation; for example, the good prognosis which is associated with the small vaginal opening into the peritoneum. The injuries to the bladder which so often make patients permanent invalids after vaginal cœliotomy do not occur with Pfassuenstiel's incision. For suture material silver wire should be abandoned; silkworm is much better. When buried it remains definitely unaltered; further, owing to its smoothness it may be easily and painlessly removed. For subcutaneous sutures and ligatures catgut only should be used. The speaker prefers iodine to Cumol catgut. He uses catgut exclusively for vaginal plastic operations. For closing skin wounds he recommends silkworm. Finally, to keep the wound completely dry Dermato vioform or phenyform shall be used. As regards vaginal asepsis he recommends repeated antiseptic douching and cleansing before operation, and before vaginal hysterectomy the uterine cavity must also be thoroughly washed out. One often finds in a uterus an accumulation of pus behind a mass of cancer. From the moment of the first incision antiseptic or, in fact, any douching must not be employed. Blood must be mopped up with dry wipes and its source controlled with catgut ligatures. Purgation and douching out of the lower bowel must be thoroughly employed before operation. G.

Indication, Technique and Results of Operations for Enlarging the Pelvis.—During the introduction of this subject at the Congress, Doderlein (*Zentralblatt für Gyn.*, 1907, No. 24) said as regards the mortality from hebosteotomy, the open method of operation seems to be followed by the same mortality as symphysiotomy. Subcutaneous hebosteotomy with four times the number of cases has less than half the mortality of the open method, and is therefore undoubtedly superior. The improvement in results is therefore not so much due to cutting the bone as to the subcutaneous manner of doing it. The cases in which the genital tract was infected before operation account for the greater part of the mortality. A special danger lies in lacerations of the vagina communicating with the wound when the genital tract is already septic, Injuries to neighbouring organs, especially the bladder, increase the danger to life. It is not certain how dangerous thrombosis of the larger vessels at the seat of operation with resulting emboli may be. It seems they are not to be feared when there are no other complications, for example, injuries to the bladder. The danger of hæmorrhage and of death from hæmorrhage requires that this operation shall be performed with every means ready to stop such hæmorrhage. Special attention must be given in cases of severe hæmorrhage to the corpora cavernosa clitoridis. As regards injuries to the bladder he says that the most frequent cause is perforation of the bladder wall with the hebosteotomic needle, particularly when the latter is sharp. In these cases the saw will also injure the bladder. The bladder may also be injured when there are extensive lacerations of the vagina. Injuries to the bladder are dangerous to life, and have a very evil influence on the convalescence in every case. The supporters of subcutaneous perforation method have the problem of divesting the technique of this danger. As regards lacerations of the vagina communicating with the wound, their occurrence is especially to be feared among primiparæ with forced delivery. To prevent them spontaneous delivery must be waited for whenever possible, When the vagina is narrow a deep incision into the vagina and perineum must be made at the side opposite the hebosteotomy. The hæmatomata which more or less arise in the majority of cases are of no importance. They only suppurate when complicated with bladder injuries. In the after-treatment adhesive plaster or a pelvic binder is not necessary. As regards the infantile results three children were dead when born among fifty-five cases of the open hebosteotomy, and twelve among one hundred and seventy of the subcutaneous method. The most frequent causes of death are cerebral injuries, such as intracranial hæmorrhages usually associated with forceps deliveries; less frequently with version and extraction. The speaker advised 6.75 cm. as the lowest measurement at which hebosteotomy may be performed. G.

MEDICAL NEWS IN BRIEF.

An Educational Health and Food Campaign.

The Lord Mayor presided recently at the London Mansion House over a largely attended meeting convened by the Bread and Food Reform League for the purpose of inaugurating an educational health and food campaign.

The Bread and Food Reform League, an educational and purely uncommercial and non-political association, is organised to direct attention to the great importance of the food question and promote the healthy nutrition of the people, and in the proposed campaign it purposes, in connection with representatives of other societies, to disseminate information which will tend to promote health and diminish many of the diseases produced by ignorance of dietetic laws. Without advocating any special system of diet, it is desired to show the nutritive and economic value of much-neglected staple foods, the more general adoption of which would benefit the health of all classes of society and lessen suffering among those of limited means. As ignorance about food tends directly and indirectly to produce infantile mortality and physical deterioration, the council of the league decided to organize the campaign, which will consist of a series of conferences, lectures, and cookery demonstrations with distribution of literature and foods. These will be held in poor districts with the co-operation of public health and other local societies, clergy, and medical men. The King has already expressed his sympathy with the objects of the League.

After the Lord Mayor had opened the proceedings, Miss Yates outlined the objects of the proposed campaign.

Sir James Crichton-Brown moved the following resolution:—"That an educational health and food campaign be held to stimulate societies and individuals interested in the welfare of the people, to make systematic co-ordinated efforts to remove this ignorance, strengthen local health committees, and influence public opinion, so that health visitors may be established to work in conjunction with medical officers of health in spreading plain practical information among the people." He said that he was not present to advocate any special system of diet, and he particularly repudiated any vegetarian tendencies, for he had no doubt that animal food as an element in the diet of the people had largely contributed to the vigour, energy, and success of our race. By establishing conferences, holding meetings, and distributing literature, it would, it was hoped, arouse general interest in food questions and hasten the day when dietetics would be regarded as an important part of the school curriculum, and when instruction in cookery would be thorough and practical. By bringing pressure to bear on the Legislature the League would, it was hoped, promote measures calculated to check the adulteration and sophistication of food at present rampant, and with reference to certain articles to establish a standard of value. so that doctored or deteriorated stuff might no longer be palmed off on the public. Sir James spoke of the necessity of educating mothers in the feeding of infants, and of the necessity for a pure milk diet, and then dwelt upon the question of the feeding of children, particularly in its relation to education. With regard to those who could feed as they would, he said that they would do well to revert to a greater simplicity of treatment than was now customary.

Dr. Heron seconded the motion, which was supported by Dr. J. F. J. Sykes, Professor W. R. Smith, Dr. David Walsh, Mr. Pearce Gould, and Dr. A. W. Mayo Robson, who dealt with various aspects of the question.

Freedom of the City conferred on Lord Lister.

More than a century ago the Corporation of London presented the Freedom of the City to Dr. Jenner in recognition of his work in the prevention of smallpox. On June 28th, in conferring the same honour on Lord Lister, the Corporation showed appreciation of another great name whose work marks an epoch in the history of medicine. The ceremony took place in the Council Chamber at the Guildhall, where, besides the Lord Mayor and Aldermen and members of the Common Council, several representatives of Lord Lister's profession were present. These latter included the President of the Royal College of Physicians, the President of the Royal College of Surgeons, Sir Henry Roscoe and Dr. Charles Martin (representing the Lister Institute of Preventive Medicine), Sir Norman Lockyer, Sir Victor Horsley, Professor Howard Marsh, Dr. L. W. Darra Mair (representing the Chief Medical Officer of the Local Government Board, who was unavoidably prevented from attending), and members of the medical staffs of several of the London hospitals.

After the City Chamberlain's Clerk had read the Declaration of Compurgators, Alderman Guthrie and Alderman Hanson, on behalf of the Merchant Taylor's Company, presented Lord Lister for the Freedom.

Sir Joseph Dimsdale, the City Chamberlain, then, delivered an address.

The City Chamberlain offered the new Freeman the right hand of fellowship, and presented him with the certificate of freedom in a gold casket amid the applause of the assembly. The casket, which has been designed and manufactured by the Goldsmiths' and Silversmiths' Company, is supported by four scroll feet in the interspaces of which are emblems relating to science and learning. The box itself bears the arms of the recipient and views of London in enamel, and is also decorated with emblems relating to Lord Lister's distinguished career. It bears the following inscription : "Presented by the Corporation of the City of London with the, Freedom of the City to the Right Hon. Lord Lister O.M., M.D., F.R.S., D.C.L., &c., in recognition of his eminence as a surgeon, and of the invaluable services rendered to humanity by his discovery of the antiseptic system of treatment in surgery. Guildhall, June 28th. 1907." The lid is surmounted by a figure representing Hygeia, and at the ends of the base are other figures, one representing the City of London offering the scroll of freedom and the other Medical Science holding out the torch of fame.

Lord Lister spoke as follows in reply : I thank you, Sir Joseph Dimsdale, from the bottom of my heart for your overpoweringly kind words. The work which it has been my great privilege to be engaged in has been its own all-sufficient reward. Perhaps I need not say that I value in the highest degree this, the greatest civic distinction in the world. If it were possible to enhance the honour you have conferred on me to-day, this has been done by the extraordinary consideration shown by you, my Lord Mayor, and your Court, for my personal convenience. Had it not been for this your extreme kindness it would have been impossible for me in my very infirm state of health to have received your gift here in this historic building.

After some customary formalities the proceedings came to an end.

The Cancer Hospital Brompton.

A conversazione was held last night in the buildings and grounds of the Cancer Hospital. The guests, among whom were a large number of the medical profession, were received by the President of the hospital, Lord Ludlow, accompanied by Lady Ludlow. Two large marquees had been erected on the lawns, and in these light refreshments were served. The grounds and buildings were suitably decorated, and the string band of the Coldstream Guards rendered an excellent musical programme. The medical and surgical staff and other officials assisted Lord Ludlow in conducting the guests through the wards and the various departments of this institution, where the facilities both for treatment and research were fully explained. The hospital was founded in 1851 by the late Dr. William Marsden, whose wife had previously died a victim to cancer. It at first contained 20 beds, but these were increased in 1883 to over 100. There are now 114 beds available, and as the hospital is quite free, "letters of recommendation" are not needed. The wards of the hospital presented a very cheerful aspect in spite of the fact that the patients were suffering from cancer. Here every form of treatment which appears to offer any possible hope of relief is given an exhaustive trial. Special beds are set apart for the treatment of cancer by remedies that are from time to time vaunted as being of use in the treatment of this terrible malady. Every case is thoroughly investigated and careful records are kept, which provide invaluable material for the study of the disease. This close association of the clinical and pathological work of the hospital is a most important factor in the investigation of cancer, for it is only by the combined study of the disease at the bedside and in the laboratory that we may expect to obtain a solution of this very difficult problem. During the last year, 817 in-patients and 17,376 out-patients were treated, and as the hospital is solely dependent on voluntary support, funds are urgently needed to meet increasing expenditure.

The Royal College of Surgeons in Ireland.— Barker Anatomical Prize for 1908.

A prize of £21 is offered for competition, and is open to any student whose name is on the anatomical class list of any school in the United Kingdom. The preparations entered must be placed in charge of the Curator on or before April 30th, 1908. The prize is offered for dissections to illustrate the muscular and ligamentous anatomy of the shoulder-joint. The preparation must be sent to the Curator of the Museum, Royal College of Surgeons, each being marked with a fictitious signature, and accompanied by a sealed envelope bearing outside the same signature, and containing within (*a*) the full name of the competitor, and (*b*) a declaration to the effect that the work of the preparation has been carried out by himself. The printed form necessary for this declaration can be obtained on application to the Curator. The dissections are to be mounted in vessels fitted with glass covers, but the covers must not be sealed down. Earthenware basins and plaster of Paris settings are not compulsory if the specimens can be equally well displayed and preserved by other means. No prize will be awarded unless sufficient merit be shown. Those competitors who enter dissections for which prizes are not awarded, but which show sufficient merit, may be refunded such amount of the cost of production as the Examiners deem fit. The costs and risks of transport must be borne by the student. The College will not be responsible for any damage the preparations may sustain ; but those of unsuccessful competitors residing at a distance will be carefully re-packed and handed to the carriers for delivery at such address as may be specified by the student.

Distribution of Prizes at the London Hospitals.

The season for annual distribution of prizes at many of the Schools of the London Hospitals has now begun. At the Westminster Hospital yesterday, the Right Hon. Alfred Lyttelton, K.C., M.P., presided ; Sir Arthur Rücker, D.Sc., LL.D., F.R.S., will present the medals and Prizes to the successful students at Guy's tomorrow at 3.15 ; whilst Professor Osler, F.R.S., will fulfil a similar function on July 11th, at 3.30 p.m. at St. Mary's. Mr. Rider Haggard took the chair at a similar gathering at St. Thomas's last week.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

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Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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For One Insertion:—Whole Page £5; Half Page, £2 10s. Quarter Page, £1 5s.; One-eighth, 12s. 6d.

The following reductions are made for a series:—Whole Page, 13 insertions, at £3 10s.; 26 at £3 3s.; 52 insertions at £3, and pro rata for smaller spaces.

Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

Tendo.—Melanotic sarcomata are most frequently derived from pre-existing pigmented spots, such as moles, and even where the growth appears to be primary or spontaneous it may frequently be traced to some unsuspected and obscure lesion, such as a pigmented spot in the rectum or vagina. But some of the melanotic growths are in all probability primary, *i.e.*, not derived from pre-existing pigmented structures.

W. H. M. (London, W.).—We might possibly publish the communication you send if the formulæ of the preparations could be also published. If the gentleman is actuated by philanthropic motives—which we do not doubt for a moment—he will surely appreciate the argument that no medical man could take the responsibility of prescribing a remedy for a patient unless he were acquainted with its composition and the effects likely to arise from idiosyncrasy or other causes through its employment. Ingredients 1, 2 and 6 would require careful watching in certain cases. We do not think that the arrangement you suggest would meet the wants of the case, as it would tend to bring us under some suspicion of commercial interest, which we should not care to rest upon us.

F. R. V.—We regret to say that we can already answer your question, for the Prime Minister announced last week in the House of Commons that he has been advised by "the authorities best qualified to express an opinion" not to appoint a Royal Commission on Cancer. He held out hopes, however, that one might be appointed when the present research students have elucidated a larger number of facts for consideration. See also our editorial columns this week.

D. O. S.—The name of the work you want is probably "Anatomia Urinæ Galeno-Spagyrica," by Henricus Martinius Dantiscanus, D.M. It was published in Frankfort in 1658, but we are not sure if that is the first edition. It is not very easily picked up, but there are a fair number of copies about.

Meetings of the Societies, Lectures, &c.

Wednesday, July 3rd.

Obstetrical Society of London (20 Hanover Square, W.).—8 p.m: Specimens will be shown by Dr. Eden, Miss Aldrich-Blake, Dr. Lewers, Mrs. Boyd, M.D., Dr. Longridge and Dr. R. D. Maxwell, and Mr. Targett. Short Communication: Dr. F. E. Taylor: Typhoid Infection of Ovarian Cysts.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Pardoe: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. W. Langdon-Brown: Some Points concerning Albuminuria, Phosphaturia, and Oxaluria.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Thursday, July 4th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Mr. E. M. Corner: Deformities of the Foot associated with Adduction.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

Hospital for Sick Children (Great Ormond Street, W.C.)—4 p.m.: Lecture:—Dr. Still: "Bilious Attacks" in Children.

Friday, July 5th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. A. Dawson: Clinique. (Eye).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

London County Asylum, Claybury.—Junior Assistant Medical Officer. Salary, £150 a year. Applications to H. F. Keene, Clerk of the Asylums Committee. (See advt.)

Royal City of Dublin Hospital.—Pathologist, Anæsthetist, X-Rayist and Dental Surgeon. Applications to Mr. G. Jameson Johnston, hon. sec. (See advt.)

Loughborough and District General Hospital and Dispensary.—Resident House Surgeon. Salary, £100 per annum, with furnished rooms, attendance, board and washing. Applications to Thomas J. Webb, Secretary, Loughborough.

Egypt.—Sub-Inspector of Ophthalmic Hospitals. Salary, £500 per annum, with two months' salary in lieu of travelling expenses to and from England. Applications to A. F. MacCallan, Esq., 32 Bedford Gardens, Kensington, W.

West Bromwich District Hospital.—Senior House Surgeon. Salary, £110 per annum, with board, residence and laundry. Applications to T. Foley Bache, Esq., Churchill House, West Bromwich.

St. Mary's Hospital, Paddington, W.—Curator of the Museum and Assistant Pathologist. Salary, £100 per annum. Applications to Thomas Ryan, Secretary,

Warwick County Asylum.—Assistant Medical Officer. Salary, £135 per annum, with board, apartments and laundry. Applications to Dr. Miller, Hatton, Warwick.

Royal Surrey County Hospital, Guildford.—House Surgeon. Salary £100 per annum, with board, residence and laundry. Applications to the Hon. Secretary at the Hospital.

The Ingham Infirmary and South Shields and Westoe Dispensary.—Senior House Surgeon. Salary, £100 per annum, with residence, board and washing. Applications to James R. Wheldon, Secretary, 74, King Street, South Shields.

West Suffolk General Hospital, Bury St. Edmunds.—House Surgeon. Salary, £100 per annum, with board and lodging. Applications to the Secretary.

Appointments.

St. Johnston, Thomas Reginald, M.R.C.S., L.R.C.P., M.S.A. (Assistant Medical Superintendent, Lewisham Infirmary, London), to be Government Medical Officer, Fiji.

Cheatle, G. Lenthal, C.B., F.R.C.S.Eng., Surgeon to the City of London Hospital for Diseases of the Chest, E.

Cunning, Joseph, M.B., B.S.Melb., F.R.C.S.Eng., Surgeon to In-patients at the Victoria Hospital for Children.

Dickinson, J. J., M.B.Cantab., Certifying Surgeon under the Factory and Workshop Act for the Tenbury District of the County of Worcester.

Flemming, Arthur Launcelot, L.R.C.P.Lond., M.R.C.S., Honorary Anæsthetist to the Cossham Memorial Hospital, Kingswood, Bristol.

Gibson, J. A., M.D.Edin., Medical Officer for the Rural District of the Isle of Wight.

Hertz, A. F., M.B., B.Ch.Oxon., Physician to the Electrical Department at Guy's Hospital.

Jordan, A. C., M.D., B.C.Lond., Medical Radiographer at Guy's Hospital.

Lewis, Thomas, M.B., B.S.Lond., M.R.C.P., Physician to Out-patients at the City of London Hospital for Diseases of the Chest, E.

Morton, C. J., M.D., C.M.Edin., Surgical Radiographer at Guy's Hospital.

Russell, Alfred Ernest, M.D.Lond., M.R.C.P., Physician to Out-patients at St. Thomas's Hospital, London.

Smith, Robert Shingleton, M.D., B.Sc., F.R.C.P.Lond., M.R.C.S., Honorary Consulting Physician to the Cossham Memorial Hospital, Kingswood, Bristol.

Thomas, Edmund J. Fairfield, L.R.C.P. Lond., M.R.C.S., L.S.A., House Physician at the Cardiff Infirmary.

Birth.

Moore.—On June 22nd, at Monage, Dartrey, co. Monaghan, the wife of Dr. Arthur Moore, of a daughter.

Marriages.

Best—Crichton-Stuart.—On June 25th, at the Church of King Charles the Martyr, Tunbridge Wells, William Harris Best, L.R.C.P., to Audrey, younger daughter of the late Lieut.-Colonel J. F. D. Crichton-Stuart.

Dickins—Taunton.—On June 26th, at St. Nicholas, Worcester, Sidney John Oldacres Dickins, M.D., of Cowfold, Sussex, to Cicely Margaret, elder daughter of William Whitchurch Taunton, B.Sc., M.R.C.P., of Worcester.

Matthew—Young.—On June 26th, at Cheadle Hulme, Cheshire, Frederick Crichton Matthew, M.D., F.R.C.S., of St. Ives, Cornwall, son of the late James Matthew, Corstorphine, N.B., to Janie Marian, elder daughter of the Rev. William Young, B.A., of Bramhall.

Trist—Owen.—On June 26th, at St. Luke's Parish Church, Chelsea, John Ronald Rigden Trist, M.R.C.S., L.R.C.P., of Putney, elder son of Herbert H. Trist, of Brighton, to Louisa Harriet, elder daughter of E. Annesley Owen, Esq., Barrister-at-law, of the Inner Temple.

Deaths.

Bentley.—On June 20th, on board the s.s. Pegu, Lily wife of Arthur J. M. Bentley, M.D., and elder daughter of the late William Butler, Esq., of Templemore, Ireland.

Rawnsley.—On June 26th, at The Hall, Mildenhall, Elsie, wife of Major G. T. Rawnsley, R.A.M.C.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, JULY 10, 1907. No. 2

NOTES AND COMMENTS.

Sir James Barr at Douglas.

AT the Annual Congress of the Royal Institute of Public Health, held at Douglas, Isle of Man, last week, Sir James Barr, who was President of the Section of Preventive Medicine, was, evidently in gay humour for he delivered a breezy address which has received more extensive report and more editorial comment than any address of the kind for a long time. The audience seem from the reports to have enjoyed the address immensely, for the report is freely punctuated with "laughter" and "applause," but the newspaper critics have for the most part been puzzled whether to take it seriously or not. The Liberal papers are indignant with Sir James for dragging their *bete-noir*, conscription, into a scientific address, and Conservative ones hope that he did not really mean anything so socialistic as a special tax on the already overburdened millionaire. One Yorkshire daily finds in the address "at least a suggestion of Rabelais," and a London evening paper thinks it "will not be far wrong," if it attributes "to pure humour" such suggestions as that physicians should be called upon to pay the funeral expenses of their patients, or that newspaper editors should be placed in the forefront of the battle in order that the nation may be rid of them. In fact to the general mind Sir James Barr's address has been most disconcerting, and everybody is asking his neighbour quite what he means. We should be sorry to take upon ourselves the *rôle* of interpreter, but it really seems as if Sir James regarded the meeting of the Congress as a little holiday, and wished to enjoy himself there. He therefore talked on all the subjects on which he had formed opinions, politics, sociology, medicine, and his friends the surgeons who made so much money, and incidentally a little public health was brought in.

Dragooning *versus* Peaceful Persuasion.

SIR JAMES BARR seems to have a particular aversion for what he calls the "Exeter Hall type of Christian, imbued with a sickly sentimentality," and the usually popular figure of John Bull. "This big, fat, plethoric, pot-bellied man is never ready for a fight of any kind," whereas, according to Sir James the ideal of manhood would seem to be a muscular Christian—not a pigmy—who is always ready to fight anyone in any place. But his great admiration seems to be reserved for German habits and the German Emperor, although, by way of letting us share in Teutonic advantages, he would have us shut out the alien. Everything English seemed to be wrong, and everything German, except the foreign alien who comes over here, about as good as possible. Well, it is a curious but happy paradox that the Britisher, with his numerous faults and with his tantalising inconsistencies and incongruities, is always a good bit ahead of the German with his military habit of obedience and his splendid organisation, so that it is possible that the physique, the health, and the spirit of the race are not so bad after all. And it would be a vast pity if opposition to public health measures were to arise by reason of English people imagining their proper liberties were to be infringed. The difference in mental habit between the Briton and the German is sufficiently shown by the course of the vaccination controversy. and public health reformers will do well to take that sad but instructive lesson to heart. It has been proved a hundred times in the past that the free-born Briton will be dictated to by no prince, priest, or governor, and in the twentieth century he is still stupid enough not to let even a doctor do what is good for him.

Infant Culture.

THERE are many signs that the teachings of what may be called the "new hygiene" are beginning to reach the lives and habits of people. True, the progress is slow, and knowledge filters rather than pours into the domestic circle; but in London already there are two schemes on foot for the prevention of infant mortality, which are both on sound lines. One of these is a school for mothers, which Dr. Sykes, Medical Officer of Health for St. Pancras, has started, and which has already achieved a certain success. No less than forty pupils are in attendance, and instruction in the proper management of the infants is bound to have a profound effect on the future health and physique of the little ones. The other movement is the establishment at St. Marylebone General Dispensary of "infant consultations" on the lines of those founded in Paris by the late Dr. Budin. Last week a meeting was held, with Lord Robert Cecil in the chair, to receive the annual report, which showed that 90 babies had been under treatment during the year, and that the benefit had been great. When our hospitals are put on right lines as consultative institutions for cases in which the general practitioner wants help, and the present overcrowded casualty departments are eased of their trivial routine work, a far more useful and noble function will lie before them, namely, that of aiding in the prevention of sickness and in the education of the poor by such means as infant consultations and the giving of hygienic advice instead of the present playful habit of doling out bottles of medicine.

A Missing Link. IT is announced that an expedition organised and equipped by the Royal Prussian Academy of Science and the Dutch Government has arrived in Java to search for the "missing link," which Professor Dubois claimed to have found there some twenty years ago. It is strange what a fascination phrases have for people. The "missing link" to the popular mind remains to be found before the Darwinian theory can be authenticated, and it is probable that it will cost as much trouble to teach them that there is no "link" missing between man and ape as that there are no lost tribes to be found or no sea-serpent to be harpooned. It is quite possible that in Java there may be some remains of pre-historic man, indeed it is said that some skulls like the Neanderthal one have been found there; but Dr. Moskowski, who leads the expedition, and his followers have as much chance of finding the "missing link" as of discovering the Golden Fleece or the Holy Grail.

Medical Referees and the Workmen's Compensation Act. THE new Workmen's Compensation Act which came into force with the beginning of this month, it is generally acknowledged, is a legal patchwork which is likely to give rise to as much difficulty in its interpretation as its predecessor. It is certain that the Government missed a great chance of simplifying its administration in not accepting the Labour amendment to the effect that in any case of dispute as to the medical aspect of the case the question should be settled by a Government referee without any legal proceedings being necessary. It is hardly to be supposed that County Court judges will take more kindly to the assistance of medical assessors than they have done in the past, and the same process in disputed claims is likely to go on with the same result, namely, that the working man whose case presents obscure medical points and the malingerer who is shamming "internal injury" will both be in the same box, and both will have an equal chance of a verdict. Nearly the whole of the liability for payment now consists in the nature and extent of the injury, and not one case in a hundred need ever come into court if a salaried Government referee were to be able to give an authoritative and binding decision on the facts, without the intervention of any legal process.

LEADING ARTICLES.

KING EDWARD'S HOSPITAL FUND FOR LONDON.

THE Bill for the incorporation of the King Edward's Hospital Fund for London having passed its third reading, it may be well to place on record a final protest against certain principles which have now been formally approved by Parliament. The modification of the clause whereby absolute control over the revenues and administration of the Fund were transferred from the President to the Council was, in our opinion, most desirable. So, also, was the change of the conditions of the presidency, which it was proposed to grant in perpetuity to the Prince of Wales during the pleasure of the King, and afterwards to succeeding presidents also appointed to office by the Sovereign. These views we have long held, and have urged, as loyal subjects anxious to safeguard the best and truest interests of the Royal Family in their public relations. With profound regret we note the failure of Dr. V. H. Rutherford, the Member for the Brentford Division of Middlesex, to secure the constitution of the Council of the Fund on representative lines. The present Council is small and autocratic, and is inevitably exposed to the risk that its administration will drift into the hands of one or two active members, who will be absolutely independent of public opinion and careless of criticism. Under these circumstances there is an ever present danger that injustice will be sooner or later done in the dispensation of grants, and there will be no appeal against a body which is absolutely irresponsible. It seems almost inconceivable that a Liberal Government, to whom representative control is as the breath of its nostrils, could permit so retrograde a step to be taken in the case of a great public trust dispensing vast sums of money. As a matter of elementary fairness and wisdom the representation, both of the medical charities and of the medical profession beyond one or two of its leading corporations, would have gone far, toward securing the permanent confidence of the community. Under the present constitution there can be no guarantee against the constant recurrence of troubles of a more or less serious nature, and we regret that a great opportunity has been lost of showing the medical profession, by a graceful concession to its wishes in the matter of representation on the Fund, that the interests of the general practitioners would not in future be overlooked as in the past by the haphazard methods of modern philanthropic enterprise.

THE HOUSING PROBLEM IN DUBLIN.

IT is a commonplace among sanitarians and social reformers that none of the many problems with which they are faced can be completely solved until the poor are supplied with suitable houses at cheap rates. As Koch has pointed out, the overcrowded, ill-ventilated houses of the poor are the breeding-grounds of tuberculosis. With airy, bright dwellings, and with due regard to cleanliness such as comfortable housing always fosters, there is little doubt that the power of this plague would soon be undermined. It is in the dirty, crowded tenements that the filth diseases also persist, breaking bounds from time to time and making their way into the dwellings of the prosperous. Typhus, small-pox, measles, scarlatina, and typhoid would, in these countries at any rate, soon cease to be dreaded if the poor were supplied with sanitary dwellings, Intemperance, too, with its attendant vices, can hardly be combatted as long as the working man has no place other than the bar-parlour where he can sit in comfort when his work is done. In Dublin the problem is as pressing as in any city in the kingdom. The tubercular rate is high, and shows no signs of diminution, while the general death-rate is one of the highest in Europe. Typhus, a rare disease in English cities, persists in Dublin slums, and the other zymotic diseases contribute largely to the death-rate. Again, in Dublin the dwellings of the poor are of a peculiar nature. As the well-to-do population has first migrated from the north side of the river to the south, and again from the south to the suburbs, the mansions and large houses it has deserted have fallen into tenements for the poor. One, two, three, or even four families, find a refuge in the room which was formerly a drawing-room or dining-room of fashion. Sanitary conveniences are insufficient or absent, and there is no attempt at cleanliness. The Dublin Corporation, which has the duty of seeing that yards, halls, and staircases are kept in proper condition, pays little attention, and as the recent report of the Local Government Board shows, the condition of the tenement houses is a disgrace to a civilised community. Certain steps have been taken, however, to substitute new dwellings of a proper nature for the old rookeries. The Dublin Corporation has spent, according to Sir Charles Cameron, £345,000 in providing dwellings for the working classes. Even at best this can hardly be regarded as more than an experiment, and it must be remembered that municipal enterprise in Dublin often entails expense without proportionate returns. As Sir Lambert Ormsby pointed out the other day, the Corporation paid £33,000 for the Bride's Alley area before a brick was laid, whereas an area similar in extent was purchased by a private company for £2,000. Much serious work has, also, been done in Dublin by various companies and trusts—the Dublin Artisans' Dwelling Company, the Iveagh and Guinness Trusts, and others—a total of 4,665 dwellings having been erected by them. So far, however, the blocks of buildings put up have been altogether in central areas, replacing the more insanitary of the older dwellings. This system has many drawbacks. In the first place it is expensive, in that a highly valued property has to be bought, for many of the old rookeries are extraordinarily remunerative to their owners. Again, it dislodges a large population, which, at any rate for the time, has to seek refuge in surrounding neighbourhoods already overcrowded, and even when the building is complete it houses a smaller number of persons than had previously inhabited the old area. It is a true charge, therefore, that each block of new buildings, while it provides excellent accommodation for a limited number of persons, actually aggravates the condition in the other areas of the city. In future undertakings it will be well to attempt the alternative of building in the country within reach of the city. Sites will be cheaper and surroundings more healthy; while the process of building can take place without the dislodgment of large numbers of people. Fortunately, Dublin is well situated for such an enterprise. It is compact, surrounded by open country, and furnished with an excellent tram system. The problem, as a whole, must be faced, and that shortly. Only the fringe of the subject has yet been touched, and the eulogiums showered on the Dublin Corporation by certain of the Dublin speakers at the recent meeting of the Royal Sanitary Institute seem to us sadly premature. With a death-rate the highest in the kingdom, to boast of sanitary progress is either disingenuous or ridiculous.

CURRENT TOPICS.

Motor Cars and Dust.

MOTOR dust has naturally come in for a good deal of attention at the Isle of Man Public Health Congress. Although of modern origin this nuisance has pervaded the length and breadth of the land with a thoroughness that cannot be gainsaid. Motor dust is not always, as some people seem to imagine, a distribution of deadly disease. Good clean country dust may not cause much damage to mankind beyond making his eyes smart and his nostrils water for a time. In a town, however, a cloud of dust may be charged with harmful microbes of all sorts and conditions of disease, which are not dissipated harmlessly into surrounding fields and hedgrows, as in the country, but find their way into our living rooms, our kitchen, our larders, our dairies, and, in a word, into every nook and corner of every habitation made with hands. The ousting of the horse by motors means the lessening of the pollution of road dust with horse manure. That is one compensation against the drawbacks of motor traffic. Others come indirectly through the necessity of bettering and perfecting our methods of road paving, and above all, of road cleansing. The President, Dr. Hele-Shaw, foreshadowed the time when the wheel of to-day would be superseded, and when it would be possible to carry heavy loads at fair speed without damage to the roadway. It is quite time that the creative genius of the nation rose to checkmate the long-standing nuisance of the motor dust.

Annual Election to the Council of the Royal College of Surgeons, England.

THE annual election to the Council of the Royal College of Surgeons, England, took place on the 4th inst., and resulted in the return of Messrs. Charters Symonds, Bruce Clarke, Mansell Moullin, and Eve. The poll was the heaviest on record, upwards of 800 fellows voting out of 1166. In the complete absence of any political questions to disturb the feelings of the electorate, each Fellow probably voted for the candidate for whom he entertained some friendly feeling. Thus on these grounds, no doubt, it has come about that the representatives of the largest medical schools have attained their ambition—namely Guy's, St. Bartholomew's, and the London. In one respect the result of the election has been somewhat remarkable, namely, in the non-success of Mr. Herbert W. Page. Mr. Page was seeking re-election, and the usual course of events, under such circumstances, is for the retiring councillor to be again returned. Such, however, was not the case so far as Mr. Page was concerned, although both his colleagues who were seeking re-election, namely, Mr. Mansell-Moullin and Mr. F. S. Eve, were successful. St. Mary's Medical School, to which Mr. Page belongs, cannot, of course, compete in size with the other large schools named, and this may have had something to do with the failure of their representative to secure re-election. The return at the head of the poll of Mr. Charters Symonds, who was competing for the first time, plainly shows the weight and influence of the alumni of a large and important school like that of Guy's. So far as Mr. Bruce-Clarke is concerned we desire to offer our congratulations upon the success which has attended his second effort to enter the Council.

"Siamese Twins."

IN the "Clinical Records" in THE MEDICAL PRESS AND CIRCULAR this week, we record an unusual case of conjoined twins which occurred in the practice of Dr. Keane Healy. The monster, which was born dead, possessed two heads, two necks, four arms, a double pelvis, four legs, but only one thorax and abdomen. This particular variety is extremely rare. Conjoined twins were divided by Dr. Playfair, who collected thirty-one cases, into four classes, namely, those having nearly separate bodies united in front to a varying extent by thorax or abdomen; those having two nearly separate bodies united back to back by the sacrum and lower part of the spinal column; dicephalous monsters, the bodies being single below, but the heads separate; and, finally, those with bodies separate below, but whose heads were fused, or partly united. Dr. Keane Healy's case, therefore, does not fall under any of these divisions for it had a complete double set of limbs, two heads and necks, but only one thorax and abdomen. To meet with such a creature is hardly, perhaps, a matter of congratulation, but it is certainly an event in a medical man's routine of existence.

Lists of Consultants and Specialists.

SOME few years ago an enterprising firm of London chemists published a list of consultants and specialists. Their publication was speedily scotched by the British Medical Association, who wrote individually to every medical man whose name was included therein. The official letter thus issued fell with the suddenness of a thunderbolt upon the gentlemen in question, whose names had been thus pilloried without their authorisation. We presume the British Medical Association will take similar notice of a publication of a similar nature recently issued by the Scientific Press, wherein a so-called classified directory of medical consultants and specialists is appended to a list of "Medical Homes for Private Patients." The proceeding is certainly not in accordance with the ordinary code of professional ethics, and the men whose names are thus paraded in the public gaze deserve our sympathy. The book is sold at sixpence. It is edited by a layman, a fact which perhaps accounts for some extraordinary omissions from the list. This light-hearted compiler, for instance, selects seven names from Scotland and five from Ireland. The most distinguished men in both countries are conspicuous by their absence. We trust that the gentlemen whose names appear and the association committee will enter their protest against this unwarrantable trespass upon the decencies of private and professional life.

An Echo of the Alcohol Manifesto.

THE echoes of the alcohol manifesto published some months ago by a contemporary in the shape of a letter signed by a number of leading medical men have already resounded far and near, and seem likely to be continued into a distant future with recurrent multiplication. The medical profession has been extensively billed with reprints by a trade journal. Some time ago a number of persons interested in temperance matters signed a memorial to the British Medical Association urging them to make a counter declaration at their Exeter meeting against the use of alcohol as a food and a beverage. The petition was duly presented by a medical man who is one of the honorary secretaries of the Exeter Total Abstinence Society. The Council of the Association have declined to accede to the demonstration. Nor is it easy to understand why the most ardent temperance reformers should not be satisfied with the counter declaration to the manifesto published some weeks ago in the columns of the MEDICAL PRESS AND CIRCULAR. We have reason to believe that our own document received less publicity from the temperance journals than the original somewhat revolutionary manifesto.

Premature Burial.

A MEETING was held in the City recently to forward the aims of the Association for the Prevention of Premature Burial, and from the accounts of its proceedings that have appeared we should judge that the blood of the audience must have run cold. One of the speakers, Mr. George G. Greenwood, M.P., related that two members of the Association had gathered together 149 cases in which people had been buried alive, 219 in which they had narrow escapes from the same fate, and 10 in which they had actually been dissected alive! We should doubtless be accused of prejudice if we threw any suspicion of doubt on the authenticity of these records, but we cannot help wondering from what source they were compiled. Were the cases culled from ancient or modern literature? And were any historians more trustworthy than the modern reporter relied upon? The person who just escapes being buried alive is a chronic newspaper canard, or rather, we should say, a recurrent one. It is due about once every three months, and it is seldom that it fails to turn up to time. No doubt lay persons who have never seen a dead body may make mistakes about the fact of death, but we would back the ordinary undertaker, and *a fortiori* any medical man, to know the difference between any trance yet invented and *horrida mors*. But we should certainly support the contention of the Association that death certification should be more carefully carried out, and that only a certificate signed by a medical man should be acceptable as evidence of death. As we have said over and over again, the present method by which a registrar may, and does, accept the word of any midwife or similarly uninstructed party as to the death of a human being, is a scandal in a civilised country. Happily, the Lord Chancellor is himself engaged in an investigation into the matter at the moment.

A Substitute for Radium.

An unconfirmed rumour comes from Paris of the discovery of a substance possessing qualities similar to those of radium bromide. The latter-day rival of Professor and Madame Curie is a medical student of Rochefort, who has only recently attained the mature age of twenty-one years. The new substance is said to cost sixteen shillings a gram, as against £120 a gram, which is the price of the radium compounds. Should this be the case a great impetus is likely to be given to radio-active therapeutics. The costliness of radium effectually prevents any extended researches into its curative and other reactions, so far as the human body is concerned. Should this rumoured discovery be confirmed, the young Rochefort student is likely to leap into fame at, medically speaking, an extremely tender age. He has bestowed upon his product the somewhat weird and mysterious name of "Molybdopp" A detail of that kind, however, is not likely to repel workers who have been unfortunate enough to break a tube of radium at a value ranging from ten to forty pounds sterling.

A Scotch Judge on the Liabilities of Chemists.

An important judgment has been made in the Outer House by a Scotch Judge, Lord Johnson The pursuer in an action sued for £500 damages in respect of injuries sustained by his daughter, five years of age. The defender, a pharmaceutical chemist, of Dundee, was alleged to have said that butter of antimony should be rubbed on the head of the child, who was suffering from ringworm. He supplied a bottle of that substance with the result that the girl lost all her hair, while her general health was also injured. Lord Johnson concluded his judgment by saying that circumstances might impose a duty on the chemist, to give warning of any possible danger from the use of the article sold of which he, as a chemist, was or ought to be aware, but of which his customer was or might reasonably supposed to be ignorant. But assuming his duty as a ground of liability against the defender, his Lordship was satisfied that the drug might be used if properly applied, or at least that the defender took pains to ascertain whether it could be so used, and was reasonably justified in believing that it could be so used. His Lordship was further satisfied that, in the first place, the defender warned the pursuer that he had no personal knowledge of its being used for the purpose in question, and, in the second place, that he warned him that if used it must be applied carefully and sparingly and only with a camel's hair brush. On that evidence, his Lordship could not hold that the defender had been guilty of such neglect of the duty in question as should render him liable. His Lordship was, therefore, of opinion that no case was made against the defender of actionable negligence. This judgment serves to show the difficulty of ensuring any efficient dealing with unqualified medical practice in the present state of the law.

PERSONAL.

At the recent International Nursing Conference held at Paris, presided over by M. J. Mesurier, the English representatives included Mrs. Bedford Fenwick and Miss Isla Stewart.

Principal Donald MacAlister has been appointed a member of the Governing Body of the Imperial College of Science and Technology.

Dr. G. D. Pidcock took the chair at a special meeting of the medical profession of Hampstead, on July 3rd, to consider the constitution of the Hampstead General Hospital.

Dr. W. R. Jack has been appointed Assistant Physician to the Western Infirmary, Glasgow.

Dr. John M. Cowan has been appointed Professor of Medicine at Anderson's Medical College, Glasgow, and Dr. Ivy Mackenzie Lecturer on Medicine at the Western Medical School.

Surgeon-General G. J. H. Evatt, C.B., President of the Poor Law Medical Officers' Association of England and Wales, took the chair at the annual meeting of that body at the Trocadero on June 27th.

The name of Dr. Charles Creighton has been placed on the Civil List for the pension of £75, in consideration of his medical and biological researches, and of his inadequate means of support.

Lord Ludlow, who was accompanied by Lady Ludlow, received the guests at the Conversazione in the grounds of the Cancer Hospital on July 2nd.

Mr. Mayo Robson presided at a conference on Milk Contamination and Distribution at the Incorporated Institute of Hygiene on July 1st.

Dr. Lehmann has been appointed by the Chinese Government, for two years, Chief Medical Sanitary Officer of Mukden.

The Council of the University of Sheffield have appointed Mr. Percival E. Barber, B.A.Cantab., M.R.C.S., L.R.C.P., Surgeon to the Jessop Hospital for Women, to the post of Lecturer in Midwifery and Diseases of Women, in succession to Dr. J. W. Martin.

Professor Alexander Macphail, of St. Mungo's College, Glasgow, has been appointed Lecturer on Anatomy in the Charing Cross Hospital Medical School of the University of London.

The Liverpool Chamber of Commerce, in connection with the meeting of the Associated Chambers of Commerce in that city in September, has agreed to contribute £250 to the Liverpool School of Tropical Medicine to establish in Liverpool an exhibition of colonial products under the direction of Lord Mountmorres. The Cotton Exchange has placed at the disposal of the chamber the old Cotton Exchange for the purpose.

A Clinical Lecture

ON

SOME OBSERVATIONS ON INTRA-ABDOMINAL ADHESIONS, WITH ILLUSTRATIVE CASES.

By E. PERCY PATON, M.S., F.R.C.S.,

Surgeon in charge of Out-Patients to Westminster Hospital.

The abdomen is now so often opened for various reasons that the condition of the peritoneum during life can be much more frequently noted than used to be the case, hence the known common occurrence of intra-abdominal adhesions in cases in which they were not previously expected, but in which they have proved to be the only, or at any rate, the main lesion, has led to their being looked upon, and with good reason, as the real cause of certain abdominal troubles. No doubt in many cases adhesions are of no importance, and do not in any way affect the health or comfort of their possessor; but in other persons, and under other cicumstances, this is not so, and they may cause symptoms which are merely of the nature of some occasional discomfort, or are much more severe, even amounting, as is well known, to the most acute intestinal obstruction.

How frequently adhesions may be expected to be found in the abdomen I know of no statistics to show, nor do I think that it is likely that any such exist; but that they must be very common is clear from the frequency with which they are seen *post-mortem*, and the way in which one comes across them when there is no reason to expect them in the course of operations.

Any form of irritation of the peritoneal surfaces may cause adhesion between one surface of peritoneum and another. This irritation may be mechanical, chemical, or due to a micro-organic infection. The first two causes mentioned will only occur as the result of injury or operation or in consequence of the rupture of some hollow viscus, while in other cases infection must be the reason for their formation. The nature of the infection may be acute or chronic; but in the acutest forms adhesions are sometimes conspicuous by their absence, as, for instance, in the following case:—

Case 1.—A girl æt. about 20, was attacked, almost suddenly, with acute pain in the abdomen, sickness and diarrhœa; she had been practically well to the day before this illness, when she had felt a little seedy, she had not been ill in any way previous to this; she became very rapidly collapsed, and I saw her about twelve hours after the onset; she was then suffering from acute general peritonitis, the cause from which was obscure. I opened her abdomen in several places in order to examine the condition of the stomach, appendix, and pelvic organs; there were universal signs of peritonitis, but no fluid and no adhesions, the surface of the membrane having a generally greasy feel; no cause could be found at the operation for the trouble; this had to be terminated in consequence of her collapsed condition, but after death it was discovered that she had a new growth in the sigmoid which had not previously given her any trouble, and no doubt the infection of the peritoneum had occurred here, though there was no perforation. The peculiar greasy feeling of peritoneum above described is commonly found, I think, in those cases of very virulent peritonitis, such as are seen not very uncommonly in connection with appendicitis, and as a rule adhesions are absent in such a condition. On the other hand, in some acute cases adhesions may be formed with very great rapidity, as I shall mention later. That micro-organisms will pass through the, to the naked eye, uninjured intestinal wall, the case just related shows well, for a culture obtained from the surface of the inflamed intestines gave a pure growth of colon bacillus.

The chief causes for the formation of intra-abdominal adhesions may be enumerated as follows:—In the upper half of the cavity gall-stones and other affections of the gall bladder, and ulcers of the stomach and duodenum, while in the lower half the appendix and in women the pelvic organs are much more frequently to blame. In addition to these causes may be mentioned any inflammatory trouble of the intestines.

That external injury may be sometimes responsible for the formation of adhesions, even when no gross lesion has occurred to the intestines, was very clearly shown by a case that had been under my care recently.

Case 2.—The patient was a man, æt. about 40, who was admitted into hospital with acute intestinal obstruction; no history of injury could be obtained from him before the operation, at which it was found that a large packet of small intestines were so adherent to one another that the kinking so caused had obstructed the gut. With a good deal of difficulty these adhesions were separated and the raw surfaces of the peritoneum carefully stitched over with normal membrane. The man made a good recovery from the obstruction, though he was attacked with bronchitis a week after and was ill for a long time with this. A subsequent further investigation of his history revealed the fact that six months before his present illness he had received a blow on the abdomen from the pole of a van, which was severe enough to lay him up for about three weeks, and this, I think, was undoubtedly the cause of the adhesions. Not improbably even in such a case the injury permits some passage of the micro-organisms through the gut wall, and it is at any rate in part to the irritation to which these give rise that the adhesions are really due.

The *form* which adhesions take varies very much in different cases; sometimes they are broad, extensive and firm, at others they are long, thin and cord- or even thread-like; it is the former kind that interfere most with the motility of the abdominal organs, while the latter are not infrequently responsible for the kinking and snaring of the gut which leads to obstruction, and may also, especially about the stomach, cause a good deal of pain.

The *rapidity* with which adhesions form is of considerable importance to the surgeon, as it is not infrequently the case that upon this he has to rely for the success of various abdominal operations, and for the prevention of the fouling of the general peritoneal cavity in sudden inflammatory attacks of the organs contained within it.

The following case will give some idea of how rapid the formations of adhesions may be :—

Case 3.—A year or two back I was asked to see a lady who was suffering from perforation of a gastric ulcer. She was æt. about 50, and when I saw her was clearly desperately ill, but in view of the fact that operation was her only chance, it was therefore done. She died two or three hours after it was finished. At the operation practically no adhesions were encountered, but at the autopsy there were many adhesions matting the various viscera together and some of these were of considerable firmness and required some force to separate them.

A very important question may be asked here, namely, do adhesions when once fairly formed ever disappear ? The answer to this query is undoubtedly Yes, as the following cases, among many others that could be cited, clearly show :—

Case 4.—A salvation army officer, an intelligent man, came to see me a little time back with a view to having a radical cure of hernia done, and at the same time having his appendix removed and a ventral hernia, which had followed on the opening of an abscess which he had had in connection with his appendix some little time before in India cured. The history that he gave was as follows : He had had an ordinary attack of appendicitis, this had resulted in an abscess, which was opened and drained by a tube which at first was about six inches long and which was kept in for at least six weeks. It was clear, therefore, that at this time the appendicular region must have been quite cut off from the general peritoneum by adhesions. When I operated for the removal of the appendix there were no adhesions about the organ whatever, and only one or two very fine omental ones in the vicinity. The appendix was removed and the ventral and inguinal hernias were all dealt with at the one operation.

Case 5.—Another case, that of a lad, æt. 18, is almost exactly similar, but in his case the wound had been packed with gauze at the operation, the appendix not being removed at the same time on account of the extensive nature of the adhesions, but when I removed the organ about a year later for recurrent pain in this region there was scarcely a vestige of an adhesion to be found.

A third example will suffice to demonstrate this point, which must be a matter of common knowledge to all who have frequent opportunity of watching surgical abdominal cases.

Case 6.—I was asked to see a child, æt. 11, who had been ill some weeks with an obscure abdominal illness which was now thought to be appendicitis. In this view I concurred and advised an operation. This was done, and very extensive adhesions were found about the appendicular region and some pus, and also an opening into the cæcum. It appeared that an abscess had formed and was discharging itself into the gut. The immediate result was, of course, a fæcal fistula, but the child's general condition was much relieved,. About six months later, as the fistula continued to discharge, I operated again and successfully closed the fistula by a plastic operation, but the point that I wish to note here is that as the general abdominal cavity had to be opened in the course of the operation, it was found that the adhesions noted as very extensive at the previous operation had now almost entirely disappeared.

There can be little doubt, I think, that the disappearance of adhesions is mainly brought about by the movement of the intestines upon one another due to their peristaltic action and, as I hope to show, the promotion of such movement is the best means of preventing their formation. This movement of the intestines upon one another sometimes leads to the strangest complexities when the bands of adhesion are long and cord-like, of which several examples are given in Treves's book on Intestinal Obstruction. In these cases the cord has been knotted or even double knotted round a coil of gut in a knot which might have been tied with the hands. This process seems to be aided when there is a long band formed which becomes free at one end and at this end there is a small thickened mass or knob which can slip through a loop previously made by the sliding movements of the gut.

The useful purpose peritoneal adhesions serve in innumerable cases is so well known that it is hardly necessary to do more than refer to the frequency with which they prevent the most serious and even fatal damage from occurring. For example, a patient is attacked with acute inflammation of the appendix which is speedily followed by gangrene, perforation and suppuration ; if the onset of the trouble be not absolutely sudden the intestines around adhere to one another, the omentum almost seems to crawl to the spot and speedily becomes matted to the guts and anterior abdominal wall, the result being that the seat of mischief is soon shut off from the general peritoneal cavity.

A very similar process goes on in association with trouble in Fallopian tubes, as in the following case which was under my care recently.

Case 7.—A woman, æt. about 25, gradually developed a mass in the pelvis of irregular outline, fixed, and with some inflammatory symptoms. Without going fully into the details, which are not important for our purpose at present, the diagnosis was provisionally made of tubal suppuration. At the laparotomy which I subsequently did this diagnosis was found to be the correct one, both tubes were found to be full of pus, and to be widely adherent to the intestines and the wall of the pelvis, these adhesions having successfully prevented the generalisation of an abscess which was found containing about four ounces of pus at the bottom of Douglas's pouch. The tubes were removed and the abscess emptied, the cavity being packed with gauze, the patient making an excellent recovery.

It would be easy to multiply examples of this sort showing the way in which adhesions limit inflammatory troubles or how they prevent extravasation of the contents of the hollow viscera. In very many abdominal operations it is merely a commonplace to say, that were it not for the rapidity with which we know that adhesions will form, many procedures would be impossible, as, for example, in the drainage of many cases of appendicular abscess. This often has to be carried out across the cavity of the abdomen, but can be done with almost perfect safety by packing the cavity with a little gauze, adhesions soon making a definite barrier. Again, in excisions of parts of the gut the union of the divided ends depends on the same adhesions of the peritoneal surfaces, but it is not necessary for me to multiply instances of a similar kind.

But it is true here, as in many other things, that "There is no rose without a thorn," and adhesions may be a source of very great trouble by tethering the viscera to one another in such a way as to interfere with their movements, thus causing pain and discomfort, interference with the passage of food in the proper direction, and therefore dilatation of the portion of the alimentary tract above the fixed spot. While in some cases the touble may be still more acute, urgent intestinal obstruction being the result. I may mention here a few examples of this sort.

Case 8.—A gentleman, æt. 40, had several attacks of appendicitis,. It was before the era of removal of that organ for such recurrent trouble, and the attacks at last ceased to recur after a long period of rest and invalidism; but though the inflammatory attacks did not come back he was still subject, over a long course of years, to occasional dragging and aching in the region of the cæcum which, however, was not sufficient to lay him up, this was particularly the case if the bowels were allowed to get loaded. There can be no doubt, I think, that these residual troubles, so to term them, were due to the adhesions around the old inflamed organ. The trouble, however, was never deemed sufficiently great to demand operation.

Case 9.—A few years ago a woman came under my care with the signs of a ruptured tubal pregnancy, in which there appeared to be no very acute bleeding but a gradual oozing into the peritoneal cavity. The abdomen was opened and the condition found as described above, the left tube, which was the one affected, was removed, and the pedicle tied in the usual way. The patient did well for the first two or three days, except for a little sickness which was thought to be due to the chloroform, as her general condition was excellent; but on the fourth day the vomiting became more serious and it was found impossible to get the bowels moved, though she passed some flatus. As this condition still continued the next day the abdomen was re-opened, when it was at once found that a coil of small intestine had become adherent to the pedicle of the tube which had been removed, resulting in a kinking which in the distended condition of the intestines caused an obstruction, the adhesion was easily separated, but unfortunately the condition had been recognised too late, and the woman did not recover. This case shows very plainly how a raw area of peritoneum may be the seat of the formation of a firm adhesion and points to the importance of, as far as may be, avoiding leaving such raw areas in the peritoneal cavity.

Another case of obstruction following adhesion which was the result of a blow upon the abdomen has recently been related in the earlier part of these remarks.

Apart from new growth narrowing of the pylorus most frequently occurs as the result of ulceration of the stomach with subsequent contraction of the scar; but it may also be due to the tying of the viscus to the under aspect of the liver and to other structures by adhesions. Of this trouble the following cases are examples:—

Case 10.—A man, æt. about 50, was recently under my care in Westminster Hospital. He had suffered a good deal from pain in the epigastrium, which did not seem to bear any very marked relation to food; on examination a mass could be felt in the region of the pylorus, the outline of which could not be very clearly made out. On filling the stomach with gas the viscus was found to be clearly dilated, its outline terminating at the mass above described, which was therefore plainly shown to be, as had been previously thought, at the pylorus. As the man was over fifty and had lost a good deal of flesh, the probable diagnosis was made of carcinoma; it was, however, thought wise to make an exploration in order to determine if anything could be done surgically. At the operation I found that the mass which had been felt consisted of a complicated collection of adhesions around the pylorus and pyloric end of the stomach, which was otherwise normal. These adhesions were separated, but no cause for their formation could be found and the wound was closed. The man did well, was relieved of his pain and began, while in hospital, to regain some of the weight that he had previously lost.

Case 11.—A similar case is that of a woman, æt. about forty, who had for several years been a sufferer from dyspepsia and vomiting. I was asked to see her with a view to operation by my friend and colleague Dr. Gossage. She had been in hospital some weeks, and during that time had vomited once or twice almost every day; she also had a good deal of pain at times of the character of heart-burn. There was nothing certainly abnormal to be felt in the abdomen until the stomach was distended with gas, when it was found to be very considerably dilated; it was therefore decided to do an exploratory laparotomy and, if necessary, a gastro-jejunostomy. At the operation the stomach was found to reach well below the umbilicus and there were a good many adhesions in various parts of the abdomen; the most important of these, however, were some very firm ones tying up the pylorus and the lesser curve of the stomach to the under aspect of the liver, the connection with the lesser curve being especially firm and broad. It was clear that these attachments interfered seriously with the power of the stomach to empty itself, and as it seemed doubtful whether they could be separated with success, and if they were separated whether they would not speedily reform; a posterior gastro-jejunostomy was done. For the first few days after the operation the patient was in a very critical condition, owing to the constant vomiting, a good deal of which seemed to be due to regurgitation of intestinal contents into the stomach. It was found, however, that by sitting her up in bed that efficient drainage out of the stomach was obtained, and, except for a slight attack of phlebitis in her left leg, she steadily improved having, as she said, not been so well for many years.

The adhesions in this case were almost certainly due to old gastric ulceration, though no definite evidence of this was found at the operation.

Case 12.—A third case of this sort was that of a man of about the same age or a little older. His symptoms were of a very similar nature and need not be detailed. At the operation his pylorus was found surrounded with adhesions which were clearly the cause of the reduction in the size of its lumen, as separation of the adhesions did not seem likely to give a satisfactory result, a pyloroplasty was done, which greatly relieved his troubles, but in a month or two these returned, apparently due to the recontraction of the pylorus. It was therefore thought wise to do a posterior gastro-jejunostomy, after which, though he for some time was subject to occasional attacks of vomiting of a somewhat severe nature he gradually improved, and when I last heard of him he was free from his troubles.

But adhesions may not only interfere with the lumen of the alimentary tract but also interfere with the bile passages and that of other ducts as the following case shows very well :—

Case 13.—Between eight and nine years ago a medical colleague asked me to see with him a case of jaundice. The patient was a woman between forty and fifty, and her jaundice had begun with some pain which was not, however, now at all severe, but she remained a deep yellow colour and had been so for about a year. There was nothing beyond a little tenderness to be felt in the region of the gall bladder, and as the case had gone on so long it was not thought likely that it was one of malignant disease, and the probable diagnosis was made of impacted gall stone in the common duct. At the operation a complicated series of adhesions was found tying up the pyloric end of the stomach to the duodenum, colon, gall bladder and small omentum. These adhesions were separated with difficulty and the gall ducts carefully examined but with negative result, so the abdominal wound was closed. The patient did well and gradually lost her jaundice, and when I saw her again, more than eight years after the operation, she was quite well, having never had any return of her trouble. In this case it seems that the adhesions caused a kinking of, or pressure on, the bile ducts, which was the cause of the obstruction to the passage of bile.

With regard to the *diagnosis* of adhesions, in most cases the only thing that can be done is to keep in mind the fact that this is one of the causes of the various troubles already referred to, and it is only at the operation that the matter can be cleared up, but a history of injury, or of old abdominal inflammation, or other cause for their formation make the presence of adhesions the more probable, more particularly when more gross diseases can with apparent safety be excluded.

The *treatment* may be discussed under two heads, namely, as preventive and curative.

By the *preventive* treatment I refer to the means which should be commonly used in the course of abdominal operations to prevent the viscera adhering to one another when this is not essential to the success of the operation. Reference may here be made to the experiments of Karl Vogel in connection with this matter. These observations were made upon guinea pigs. After opening the abdomen and somewhat irritating the surface of the peritoneum in such a way that in the ordinary course adhesions would have formed, various substances were used to try and prevent their formation, such as a solution of gum arabic, olive oil, paraffin, saline solution or the interposition of oil silk which was removed in the course of a day or two. None of these means, however, were found to be very successful in procuring the end in view. Experiments were made to determine if by promoting peristalsis during the after-treatment better results would be obtained; the animals were therefore fed on such food as beetroot, which was known to cause frequent movement of the bowels, and also were treated with atropine or physostigmine with the same end in view. This treatment not only promotes movement of the intestines on one another but also prevents distention, and so pressure of the intestines against one another. It was found that by this line of procedure adhesions were much less frequently and extensively produced.

From these experiments, and also from clinical experience, it may therefore be said that to prevent the formation of adhesions after abdominal operations every care should be taken at the operation to avoid anything that is likely to irritate the surface of the peritoneum, and to this end asepsis, rather than antisepsis, should be aimed at; sterile swabs or sponges and sterile saline solution being used rather than antiseptic swabs and antiseptic lotions; at the same time pains should be taken as far as may be not to rub or irritate or break the surface of the peritoneum more than is absolutely necessary, and when it is feasible to cover in raw surfaces uncovered with peritoneum by carefully suturing a layer of that membrane over such areas.

The *preventive after-treatment* is no less important than the method of doing the operation, and should be along the lines indicated by the experiments detailed above, that is to say, the bowels should not be kept confined, but should be moved at an early date unless this is especially contraindicated by the nature of the operation. As mentioned above, this serves two purposes as far as adhesions are concerned, namely, it causes movement of the intestines and so prevents two coils from lying constantly in contact with one another, and also at the same time prevents distention, and therefore pressure of the intestines and other organs against each other. Quite apart from the prevention of adhesions this line of after-treatment, which is exactly the reverse of that adopted in the early days in the management of abdominal sections, has other advantages, and it is familiar to all who have much experience of such cases how very different is the condition of a laparotomy patient before and after the first free evacuation of the bowels subsequent to the operation.

I do not think that the particular means to be used for opening the bowels is of very much moment. Personally, I generally give five grains of calomel the day after the operation and follow this with a turpentine enema containing half an ounce of the oil about five or six hours after the calomel has been given. If the enema does not have a satisfactory result it can be repeated in the course of an hour or two and a further dose of calomel given later if necessary. The administration of the calomel in one grain doses every hour till the bowels are moved has been strongly recommended by some, but I have not adopted it as it has seemed to me to cause more griping than the method described. Some prefer to give magnesium sulphate, but I have found that it is usually rather more difficult to prevent the patient bringing this up than the calomel when it is given before the anæsthetic sickness has entirely passed off or when it has only just stopped; it may, however, be given with advantage, I think, if the first dose of calomel does not act satisfactorily. I have not tried atropine or physostigmine as recommended by Vogel on the ground of his experiments.

The *curative* treatment of adhesions that have already formed is carried out on just the same lines as indicated above, after the attachments of the organs to one another have been separated; this has been exemplified by one or two of the cases recounted. Unfortunately, however, in some cases the adhesions reform in spite of every care at the operation and in the after-treatment; also in some cases the connections of the viscera to one another are so dense, and so extensive, that to divide them would be too hazardous a procedure while at the same time the likelihood of preventing their reformation, if so extensive, would be very small; under such circumstances a gastro-jejunostomy or a pyloroplasty, as was done in two of the cases that I have described, or some similar operation in different circumstances, may be found to give satisfactory results.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Seton Pringle, M.B., B.Ch. (Univ. Dub.), F.R.C.S.I., Surgeon to Mercer's Hospital, Dublin. Subject: "The Treatment of Carcinoma of the Great Intestine."*

ORIGINAL PAPERS.

THE GENERAL PRACTITIONER.

I.—His Outlook.

By J. LIONEL TAYLER, M.R.C.S., L.R.C.P. Lond.

The position of the general practitioner needs re-defining. He has gained in knowledge; to some extent in social recognition, and his responsibilities have greatly increased. Yet his status in the medical profession has hardly changed from that which it was nearly a century ago.

He has gained in Knowledge.—Writing in 1803, Thomas Percival, in the then standard work on "Medical Ethics," quotes with approval Adam Smith (*a*) to the effect that the apothecary "is the physician of the poor in all cases and of the rich when the distress or danger is not very great." This same apothecary, who had a very imperfect medical training, dispensed his own medicines, and Percival condemns the practice of a physician sending prescriptions to the druggist rather than allow the apothecary who is consulting with him to do it himself, and charge the patient for his trouble. He adds, however, that the physician should occasionally inspect the drugs that the apothecary uses, so as to see that they are satisfactory. In the whole work it is made clear that the apothecary is inferior in all respects to the physician, as at that time in the large majority of cases he undoubtedly was.

In 1849 a third edition of this work was re-issued and as it still seems to have been regarded as authoritative, and as no comment on the old passages dealing with the status of the apothecary were inserted, it may be taken that the view presented was still more or less representative of the times. Kerrison, (*b*) however writing in 1814, after quoting the same passage from Adam Smith, asserts that the surgeons now constitute "the most numerous class of general practitioners in England and Wales," while Mackenzie (*c*) writing on "Specialism in Medicine," seems to place the beginning of the tendency of consulting physicians and surgeons to specialise somewhere about 1860. Therefore, the low standard of medical efficiency exhibited by the general practitioner began to be modified somewhere about the second decade of last century, if we are to trust Kerrison. It was still a low one in 1849, but from this time a gradual improvement took place, so that the consulting medical practitioner commenced to specialise in particular branches of medicine, because presumably more specialised knowledge came to be better appreciated.

There can be little doubt that the better qualification and culture of the general medical man has caused him to rely more upon himself in all diseases that he is familiar with, but probably also to seek more freely advice for disorders that are unfamiliar. This change, be it noticed, alters the relation that has hitherto existed, for the position is no longer that of inferior and superior, but of generally experienced and specially experienced workers. His status being no longer a subordinate one, his authority in medical matters should be more recognised.

The Gain in Social Status.—It is indisputable that the medical practitioner's social position has improved. One has only to glance at the earlier and later literary writers of last century to realise this fact. Dickens, and earlier men make this evident. The Bob Sawyer type of student and practitioner; the surgeon swearing at his patients, though these are varieties that may still exist, are yet now in such marked minority as to be no longer representative of any section of the profession to which they belong. And the general public, whatever view it may take as to capacity, has recognised the greater refinement that has become evident as a result of better education in our profession.

His Responsibilities have Increased.—This point like the last is a commonly acknowledged fact. Since 1870, when the education of the poorer classes of the community became recognised as a public necessity, the medical practitioner has had more and more responsibilities in reference to school questions thrust upon him. And, before this, factory legislation has given him both an interest and an incentive to study employment liability risks, and assurance societies have accentuated the tendency.

The fact that patients are now far more ready than formerly to detect failure of skill in their medical attendants has raised the general standard of efficiency, but it has also added much to the anxiety of medical practice.

Yet his Status in the Medical Profession has not Improved.—It is a curious fact that, in spite of this obvious upward change, both in his own capacity and in the class of practice which he has had to undertake, the general practitioner is still regarded as being largely the inferior of the specialist, precisely as the old apothecary really was to the more skilfully trained physician. His representative rights are very little improved. His voice

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(*a*) "Wealth of Nations." First published in 1775.

(*b*) "An Inquiry into the Present State of the Medical Profession in England."

(*c*) "Essays."

is seldom heard in the medical journals, and he is never invited to contribute to the larger medical text books or to deliver lectures at medical training institutions. In every respect he is treated, though courteously, as a subordinate whom the principal has nothing to learn from. This attitude cannot fail in the end to lower the general practitioner in his own estimation and cause him to take less interest in his work, and it must be finally disastrous to the whole medical profession.

It is claimed by the writer of these articles that the general practitioner has a *distinctive* position of his own, which the specialist is quite unable to represent; that his position should therefore no longer be a subordinate one as heretofore. The simple difference between him and the consultant being wholly and solely one of aspect of approach to common studies. Hence, if these contentions are sound, it will be evident that a change in his professional status is advisable, corresponding with the change in the character of his work.

I hope to take up "The General Practitioner's Claim to Recognition," in my next essay.

FRACTURES OF THE SHAFT OF THE FEMUR—A DISCUSSION ON THEIR TREATMENT AND DIAGNOSIS. (a)

By SIR THOMAS MYLES, M.D. Univ. Dubl., F.R.C.S.I.

Surgeon to the Richmond Hospital.

FOR a long time past it has seemed to me that surgery, while advancing by leaps and bounds in other domains, has been singularly unprogressive in the matter of fractures, especially of fractures of the thigh. One reads every day in the journals, records of daring and brilliant operations in the abdomen thorax or cranium. Suggestions full of careful thought are made by many workers in these fields, but, so far, little progress has been made and, with a few exceptions, but little surgical thought has been bestowed on the subject I have chosen for my communication. In this particular branch of surgery the surgical mind seems to have fallen into what Swinburne calls "the slothful hebetude of the grave." We are still not merely in the early Victorian age—that era of ugliness—but it is hardly an exaggeration to say, in the days of Galen and Hippocrates. The full tide of human thought has swept past us, engulfing old landmarks in almost every direction, but here a rigid conservatism apparently offers an insurmountable obstacle to progress, and one still sees in a most up-to-date hospital, fully equipped with the costly appliances demanded by modern surgical technique, patients with broken thighs treated by practically the same methods as their predecessors have been treated for the last hundred years, or even more.

Very few appear to consider the subject worth giving more than a passing thought to, and the result is that progress has been practically nil. And yet the subject is worthy of the most careful consideration, as I hope to show very soon. One reason why it had so little consideration bestowed on it, perhaps, is that medical men themselves rarely suffer from fractures of the femur, in this respect contrasting markedly with appendicitis, enlarged prostate, and other more widely diffused ailments, the prospect of being a possible subject to each or any or all of these maladies being constantly before our mental vision, thus stimulating that imaginative faculty which is essential for novel suggestions. If medical men themselves were more frequent sufferers from these injuries they would long since have rebelled against the traditional methods of treatment, and more modern methods would soon have displaced the older ones.

Fracture of the femur is not a common accident; practically it presents itself amongst two classes of the community only—the workingmen and the sportsmen. Of course, it may happen to anyone in a railway or other accident, but, speaking broadly, it is met with most frequently amongst the classes I have mentioned. Now it may not be of any great consequence to a millionaire or a salaried official to be lame and weak in one leg, but it means a great deal to a hunting man, and still more to a workingman, whose bread depends on his muscular efficiency. The first question I have set myself to consider, therefore, is that of the prognosis in such an injury in a workingman or a hunting squire. Is a workingman as efficient after this accident as before, and can a sporting man ride, shoot, play cricket, tennis, etc., as well as he used to before he broke his femur? The answer to these questions can be supplied in part by one's individual experience, and in part by a study of museum specimens and X-ray photographs. My own experience of the result of routine treatment in these cases is not very encouraging. I have found that in nearly all cases occurring in adults there has been considerable shortening and consequent lameness, some stiffness in the knee-joint, some limitation of the movements of rotation at the hip-joint, a varying degree of muscular atrophy, pain with changes in the weather, and almost always an ugly nob of callus to be felt or seen at the seat of the united fracture. Some of these patients amongst the well-to-do found that riding became painful afterwards, probably from the pressure of a bony projection on some of the nerve trunks; none of them could run or jump as they used to do, and they all suffered for some years after from coldness and œdema of the foot on the injured side. At first I felt inclined to blame myself for these results, but further study of the subject soon taught me that they are the invariable and inevitable results of the methods of treatment usually adopted—methods sanctioned by tradition and the teaching of the schools.

A study of the museum specimens of this injury is very instructive, and calculated to modify one's previous conception of what actually takes place in these cases. We are not all pathologists, nor have we all access to museum specimens, by the study of which we may hope to educate ourselves; consequently we are not much to blame if our imaginary conception of what takes place in these injuries is found to differ very materially from the actualities presented by museum specimens. I remember once, some years ago, asking a well-known surgeon of great intelligence—now, alas! no more—if he found as great difficulties as I had in effecting even decent approximation of the broken ends in fractured femur. To my astonishment he told me that under an anæsthetic he had never any difficulty in effecting perfect end-to-end apposition in transverse fractures, and that he always got good results in such cases! I could only congratulate him on his good fortune, and envy him the mental condition which enabled him to hold such a belief. Now such a belief—absolutely foundationless—is fairly widespread. The general idea amongst such believers is that it is not difficult under complete anæsthesia to get end-to-end apposition of the fragments, that they can be held in this position by splints, weight and pulley arrangements, etc., and that a nice spindle-shaped lump of callus surrounds and holds the ends together, and that the patient's leg is just as well as ever after the fracture, if not a little better!

It is a very curious fact that amongst the many museum specimens of this injury I have examined I have never yet had the good fortune to meet one illustrating this method of union. One is either forced to believe that the museum contributors for several generations have wickedly combined to exclude such specimens from their collections or, *horribile dictu*, that such specimens do not exist. That the latter is the more probable explanation is supported by a study of X-ray photos of these injuries. Of these there are a great many now in existence, and men who have made a special study of X-ray work—such as Dr. R. Lane-Joynt and Dr. W. Haughton—tell me that they have no specimens in their collections illustrating this traditionally-accepted method of union.

(a) **Read before the Royal Academy of Medicine in Ireland (Section of Surgery) May 10th, 1907.**

As a matter of fact a study of museum specimens and of X-ray photos show certain constant factors in these cases :—

1. There is always shortening due to overlapping of the fragments.

2. The lower fragment may be in front or behind, inside or outside the upper fragment; it is never exactly where it ought to be.

3. The lower fragment is rotated either inwards or outwards; it is never in perfect alignment with the upper. It may be in approximate alignment, but it is never in the perfect alignment, and it cannot be.

4. It is absolutely impossible to decide by the unaided eye, touch, or measurements what the actual displacement of the fragment is. The mass of muscle surrounding the bone, the extravasated blood, the enveloping skin and fasciæ all combine to soften the asperities of the actual outline in the same way as a fresh fall of snow smooths out and diminishes the irregularities of contour in a landscape. It is the tell-tale X-ray which shatters one's hopes and shows us that the limb, after all our effort, is little better than a whitened sepulchre; that we are still far indeed from the realisation of our ideal. The amount of actual bony displacement that may exist, completely masked by the soft parts, is incredible to all save those who have studied this question with the aid of X-ray photos. Let anyone glance for a moment at the specimens illustrated here and he will, I think, have no difficulty in understanding why such patients complained of pain and weakness in the limb, of marked lameness, of coldness and œdema of the foot below nor is it more difficult to understand that men so afflicted can no longer ride, run, swim, or tramp across a moor, gun in hand, as they did before their accident. It is, I think, fairly obvious, therefore, that fracture of the shaft of the femur is a very grave accident indeed, and one well worthy of the most careful consideration.

Hitherto surgeons have quietly accepted the teachings of the great men of the past, that shortening of an inch or more is the inevitable outcome of such injuries, and that nothing can be done to prevent it. But surely this is an unworthy position to take up at this period of the world's history. Are we not bound to make use of all the advantages that progress in other directions has made available for us? Is the technique which has made safe the great operations in other branches of surgery not to be utilised in this particular branch of our work? Are we bound to doom a young man to lameness and inactivity for the rest of his life through lack of courage to face a comparatively novel problem? My plea is for greater boldness in dealing with these cases; that in suitable circumstances we should not deny them the advantages, added risks notwithstanding, which the improvements in modern technique have placed within our reach. Let the facts be stated frankly and plainly to our patients; let them understand clearly the risks and advantages on the one hand, the freedom from risk and disadvantages on the other, and I am convinced that the average young man will not hesitate to face the risks inevitably incidental to all operative methods.

There is one other point to which I should like to refer before leaving this part of the subject. Hitherto the loss of muscular efficiency in these cases has been attributed to the shortening due to the overlapping of the segments and possibly to some angularity at the seat of union. While not denying that these factors play a prominent part in producing the ultimate result, I am convinced that too little importance has been attached to the want of perfect alignment in the united fragments. Somehow most of us in making a mental picture of the femur consider it as roughly a straight bone, slightly convex forwards. Take a normal femur and study it carefully; it is by no means a straight bone, but a series of curves and angles. I need not attempt here to give a verbal picture the anatomy of the femur. It is to be found with more or less accuracy in every text-book of anatomy. But if we look carefully first at a normal femur and then at any of the specimens of united fracture in the museums, we cannot fail to see how large a part the inevitable lack of perfect alignment must play in producing the diminution of muscular efficiency which is so painfully apparent in these cases.

No method of treatment other than exposure by dissection holds out any hope of a perfect restoration of alignment. It is only by actually seeing the parts dove-tailed back into their original positions that we can ensure perfect alignment. Apart from this operative exposure, the most careful measurement, palpation and manipulation are in vain—even the X-ray itself fails us here. True we can rotate the lower fragments inwards or outwards, but practically we can neither precisely determine the actual position *qua* rotation of the upper fragment, nor can we adequately correct it if we wish to do so by any appliance at present at our disposal. I am quite aware that in urging the more frequent use of operative methods I am assuming a grave responsibility, and this responsibility I propose to diminish by certain limitations. In the first place, operations of the kind to be described hereafter should not be undertaken by men other than those engaged in daily operative work at the hospitals. They should not, save in very rare cases, be undertaken in private houses. They should never be performed save in healthy youths or adults.

A very perfect technique must be at the operator's disposal, and plenty of skilled assistants. The operator must have an adequate armamentarium, and his requirements in this direction should be determined by previous experiment on the cadaver. Given all these preliminary requirements, operations on fractured thighs should not be more hazardous than any of the countless operations performed in the hospitals of a great city throughout the year. It is fairly well known now, thanks to X-ray photography, that the broken ends of the fragments present great diversity in the minute details of their appearance. Sometimes the bone is broken nearly square across, with or without partial or complete detachment of angular fragments. In others the line of fracture is of varying degrees of obliquity, ranging from one to as many as five inches in length. In cases of extreme obliquity, the long axis of the bone seems to be almost bisected, so that each segment offers but little holding ground for any mechanical appliance to be embedded in. In others, again, the line of fracture is an irregular spiral; while in some the bone may be extensively comminuted. It is obvious, therefore, that it will be very difficult to make any one method of treatment equally efficient for the treatment of these divers conditions, and the surgeon who proposes to substitute operative for non-operative methods of treatment must be prepared to modify his plans as the actual conditions to be dealt with are revealed by X-ray examination, and by the preliminary exposure of the seat of fracture.

The methods I now propose to discuss are of three kinds :—

1. Simple wiring of the fragments together after exposure and drilling.

2. A modification of the ingenious apparatus suggested by Mr. Park Hill, of Denver.

3. The use of short steel screws as recommended by Mr. Arbuthnot Lane.

SUTURING WITH WIRE.

Even with the most perfect equipment the securing of a plain transverse fracture by drilling and wiring is a task of great difficulty. To get the parts rigidly into position at least four separate wire sutures must be passed, each suture entering the periphery of one segment, then emerging through the medullary canal at the seat of fracture, re-entering the medullary canal of the other segment and emerging at its periphery. If four such sutures can be passed and secured with a uniform degree of tension, an excellent result will be achieved. But practically this is impossible to accomplish. One suture must be at the side of the bone remote from the surgeon, and this suture it is practically impossible to make secure. Assuming that the ends of the fragment have been projected through the wound and duly drilled, the sutures can now be passed, with some difficult manipulation no doubt, but still the four sutures can be passed and got into position for tightening. Now comes the crux. The segments when reduced are overlapping. This overlapping has to be overcome by traction on the lower segment, but this very traction now makes the aponeuroses and muscles so tense that there is no room for one's hands to grasp and make traction on the suture most remote from the operator, and if this deepest suture is not made taut a hinge movement will be permitted by the other three—not only will a hinge movement be possible, but even a worse result may happen, namely, that the lower fragment may slide so far outwards as to be ultimately in lateral, not end-to-end, apposition. This result is due to the fact that so-called flexible wire, iron or silver, is never so flexible as silk or other common suture material. It is mechanically impossible to make wire sutures as tight as silk could be made around the four angles which each suture must traverse. Further, any slight initial relaxation that may have occurred at the operation tends to increase from day to day, partly by actual stretching of the wire itself, partly by the absorption of the bone from pressure at the drill holes. If the broken faces can be kept squarely in position these changes do not occur, but if the least lateral movement is allowed by the presence of the fourth suture the factors described at once become operative. I do not mean to say that this is a fatal objection to the method, as the defects may be neutralised by splints, but then one great advantage of the operation is lost—viz., the ability to dispense with the splints altogether and to procure immediate fixation of the fragments in their original relative positions. A consideration of these factors and practical experience have led me to abandon the simple wiring method in clean cut transverse fractures.

In oblique fractures the problem is totally different, and here the wire may be used most effectively. The method I have adopted in such cases is as follows:—An incision is made on the outside or in front, and the segments examined by both sight and touch. In these oblique fractures it is usually fairly easy to determine the previous relations of the spikes and recesses on the two fragments to each other. Once this is done it is easy to drill at least one hole in each segment in such a position as will give satisfaction afterwards. It is not advisable to drill the bone directly at right angles to its long axis. It is better to drill it obliquely, that is to say, to drill the lower fragment at a slightly higher level than the upper. This makes the wires more tense when the muscles tend to draw the lower segment upwards. This difference in level must not be too great, as then there will be a thread of wire intervening between the fragments, preventing perfect apposition. It may be advisable to drill a second, or even third, hole, but in the long oblique type one drill hole is sufficient—the upper and lower ends being simply secured by a circular lashing of wire or chromic catgut.

THE PARK HILL METHOD.

The method that I think, on the whole, promises to give the best results is that associated with the name of Mr. Park Hill. The principle underlying this method seems to me to be very sound, though in the original appliance certain mechanical deficiencies became apparent on use. These deficiencies have been largely corrected by adopting the suggestions of my friend, Dr. R. Lane-Joynt, whose mechanical aptitudes are so well known, and are placed so freely at the disposal of his professional brethren.

The apparatus which he has devised and perfected and which I am now using fairly extensively, may be described as follows:—First let me understand the fundamental principle on which the instrument is based. Everyone is familiar with the fact that a fractured tibia undergoes but slight displacement if the fibula remains unbroken. To Mr. Park Hill belongs the credit of proposing to supply to a broken femur or humerus an artificial equivalent of the fibula in the lower limb. To do this several holes are drilled in the upper and lower segments of the broken femur, at right angles to the long axis of the bone In these holes long, strong, steel screws are firmly embedded, their free ends projecting six or seven inches, or more, beyond the muscles and skin of the limb. If these free ends are now caught in a long clamp, so strong and so tightly clamped that the screw cannot move, it is obvious that the clamp becomes practically an artificial fibula to the femur, and it is equally obvious that if the fragments have first been absolutely restored to their original position, and when so restored that the clamp has then been tightened on the screws, nothing short of a great violence can disturb the bony segments. When first using this apparatus we met with certain mechanical difficulties, and all the modifications suggested and executed by Dr. Joynt have been designed to overcome these difficulties.

First you have the difficulty arising from the fact that the femur is curved slightly, and the clamp sides are striaght. In other words, assuming that four or six long screws are put from outside into the shaft of the femur, say one inch apart, and exactly equidistant from the anterior and posterior surfaces of the bone, a line connecting the external ends of these four or six screws will be a curved line, while the sides of the clamp that hold them are in a straight line. The result of tightening the clamp, therefore, will be to tend to diminish the normal forward convexity of the femur. On the other hand, if the sides of the clamp be curved, it will be necessary to equip oneself with a number of clamps to suit the varying degrees of femoral convexity and the exact seat of the injury. Again, if six screw holes have to be drilled in the shaft of the bone, to ensure that they are exactly in the proper line, each equi-distant between the anterior and posterior surfaces, it will be necessary to make an enormous incision, and to expose the bone over a very large area. These difficulties have been overcome in Dr. Joynt's modification of the apparatus by interpolating a universal joint, capable of being rigidly locked in the middle of the clamp. This device makes the instrument easier of application, and increases its efficiency enormously. Thus it is no longer necessary to make a huge incision, exposing the bone over a large area. It is now sufficient to make one incision, say two inches in length, at the seat of fracture, to enable the operator to see and feel that perfect adjustment has been accomplished. The screws, four or six in number, are inserted through small puncture wounds at some distance from the site of fracture. So long as those in each segment of bone are fairly well in line it is immaterial if those in the upper segment are not at first completely in line with those of the lower, as to be rotated in any desired direction until perfect alignment of the segments is obtained, when the clamp can be easily locked securely.

Parenthetically I may say here that the farther from the seat of fracture that the top and bottom screws are inserted the greater will be the mechanical advantages of the method in securing absolute rigidity in the fracture.

The method is not suitable for children, as the femur is too small in calibre to carry the screws well, and force applied through the screws, using them as levers, may cause longitudinal fractures of the bone; but for uncomplicated cases in adults it promises to be the easiest and safest method yet devised. Moreover, in fractures near the trochanters above, or the condyles below, it is incomparably superior to any method of wiring or the use of screws. It is in fractures near the trochanters that the most hideous results are met with from the ordinary treatment by splints, flexion of the thigh, bandages, etc. The upper segment in these cases is seriously displaced; being usually flexed, abducted and everted, the lower fragment is drawn up inside and behind it, so that when union takes place the result is something which resembles the striking end of a polo mallet. The shortening and irregularity are not the worst features, however. Owing to the abduction of the upper segment the top of the great trochanter is approximated to the pelvis, so that when union has taken place actual abduction becomes impossible owing to the top of the trochanter striking against the pelvis. Further, it is practically impossible to maintain any real extension by strapping plaster fixed above the knee only, a limitation necessitated by the flexion of the thigh required to bring about even approximate parallelism of the two segments.

Another point not to be forgotten is that in the fractures close to the trochanter minor splints applied in front exert little or no pressure on the upper segment, owing to the fact that a bandage around the thigh at the level of the perineum is really below the end of the upper fragment. Similarly the fractures near the condyles, where great distortion occurs through the rotating influence of the calf muscles, the Park Hill apparatus promises to be of great service. In this situation wiring is, from anatomical and mechanical reasons, very difficult, involving great labour and prolongled exposure of the parts, whereas even a very small lower fragment will permit of the application of two screws, one of which may be inserted into the condyle itself if necessary. The clamp and screws are left *in situ* for about four weeks, when, in a healthy patient it will be found that fairly firm union has taken place. One very striking clinical fact about the use of this method is the immediate relief from pain that the patients obtain. All muscular spasm seems to cease, good sleep is obtained, and the discharge of the natural functions is no longer an ever-recurring painful ordeal. If the technique has been perfect one dressing suffices for the entire case. When this dressing is removed a number of small crusts are found around the apertures in the skin through which the screws emerge. These latter are gently withdrawn by unscrewing. They should not, even if loose, be pulled out. In a few days' time the minute channels have healed and the patient is practically well, with a limb, save for the muscular atrophy due to inaction, as efficient and useful as before his injury. In all these operations it will be advisable to have X-ray photos taken at intervals from points 90° apart, to ensure that perfect apposition is being maintained throughout.

THE USE OF SCREWS.

This method, which owes its origin to the suggestion of our brilliant countryman, Mr. Arbuthnot Lane, is well worthy of a more extended trial than it has hitherto received. It is especially applicable to cases of oblique fractures; the greater the obliquity the better, provided that the ends of the bone are not comminuted. The method of employing screws has been given with such amplitude of detail by Mr. Arbuthnot Lane that it is not necessary for me to refer to it here. A word of warning, however, is necessary for those who are yet practically unacquainted with the method, but may wish to make a trial of it. It must not be forgotten that to ensure getting the screws exactly into correct position; the fragments must first be accurately reduced, and then firmly held in position by the special forceps designed for the purpose. This necessitates rather a free exposure of the bone and detachment of the muscles from the areas grasped by the forceps blades. If this is not done necrosis of the crushed muscle fibres may ensue and afford a nidus for infective organisms to develop in.

Again, in the small bones of women and boys the screws hardly get enough grip to make secure union. In the adult this objection does not hold, and excellent results indeed can be obtained. In fact, in a satisfactory case, the after result of the use of two well-placed screws is, to my mind, better than that obtained by any other method, but it must be acknowledged that it requires a higher degree of mechanical aptitude to use the screws properly than to employ the wire or the Park Hill apparatus. One has also to keep clearly before one's mental vision the position of the femoral vessels, that they may not be injured by the ends of the screws coming through the bone, and the length of the screws to be used must be very precisely determined before insertion. All the precautions as to riming the proximal compact layer of bone so as to allow of depression of the head of the screw, insisted on by Mr. Lane, must be carefully adopted if success is to be achieved. It will, of course, be understood, that in this method the incision to expose the fracture may be in front, or outside, as may seem most convenient, but the presence of the femoral vessels prohibits incision on the inner side of the thigh.

Recently an ingenious suggestion has been made to use an aluminium plate as an imbedded splint by fixing it with screws to the two fragments and closing the wound over the lot. I have no practical experience of the method, and therefore do not venture to offer an opinion on its merits. Further experience by its originator will doubtless in time enable us to contrast its comparative efficiency with the methods described above.

In concluding this communication I may be permitted to offer a word of advice to those who may desire to practise one or all of these methods, but as yet are without practical experience on the subject.

1. Find out as much as you possibly can as to the exact condition of the broken bone at the seat of fracture by a series of X-ray photos.
2. Think out very carefully beforehand which method is likely to give the best result.
3. Drill the bone with a Morse drill set in a brace.
4. If using the Park Hill screws see that the tap for cutting the screw thread in the bone is of exactly the same size as the screw to be inserted later, and is but little larger than the Morse drill.
5. Never try to hurry the tap, let it cut its own way in the bone.
6. When the ends of the fragments are exposed, measure their diameters and mark the screws at a point from their buried ends, exactly equal to this depth, so that they may not project through the bone, and perhaps injure the vessels.
7. If using the Park Hill method remember that the wooded faces of the clamps taken from the boiler wet will shrink as they dry, and the screws holding them in position must be tightened in an hour or so.
8. Take an X-ray photo the next day from two points 90° apart to insure that position is maintained.
9. Remember that to pass a ligature around the bones a very large and powerful needle must be used as the tough tissues about the linea aspera offer a considerable obstacle to the passage of a needle.

Lastly, practise the operation on a cadaver before trying it on the living.

CLINICAL RECORDS.

AN INTERESTING CASE OF BIRTH OF "SIAMESE TWINS."

Under the Care of J. Keane Healy, L.R.C.P.I., L.M.,

Miltown Malbay.

The following case, in general practice, will, I think, interest many of your readers:—On June 15th I was called to attend Mrs. M., who, I was informed, was sick in her third confinement for twenty-four hours, and attended by the district nurse.

On arriving, after a drive of ten miles, I examined her, and found a foot presenting through the membranes. The os was fully dilated, and on rupturing the membranes, a great quantity of water came away (at least five or six quarts). On again examining I found a second foot; but on making traction I could not bring down the birth. On making very careful examination I found two other feet protruding and, of course, came to the conclusion that it was a case of twins. I attempted to get back one of the twins, as I thought, but failed. I then got down the four legs and found I had to deal with a case of Siamese twins. I gave the patient a few whiffs of chloroform and made traction on the whole thing which (to my agreeable surprise) came away in a slop, without the slightest injury to the maternal parts. The mother has made a rapid recovery.

On examining the birth I found it had two heads, two necks, four arms, one thorax, one abdomen, one tunis, four legs, double pelvis, with anus and vagina in each, all fully developed. Mrs. M. did not expect her confinement for three weeks after this occurred. Of course they were born dead. I did what I could to get hold of the birth, but failed, as the father would not consent to give it. They were united from top of sternum to the double pelvis.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Thoracotomy.—Mr. **Willmott Evans** operated on a case of empyema. The patient was a woman, æt. 23, married, who had been admitted into the hospital three days before the operation. A month previously she had had an attack of acute pneumonia, and two days later she was confined of a living child at full term. A day or so after this, the doctor who was attending her diagnosed a pleural effusion on the right side of the chest, and three ounces of serous fluid were withdrawn by an aspirator. Since then she had suffered much from pain in the chest and cough, and her temperature, instead of subsiding after the pneumonia, varied between 102° and 103°. An empyema was diagnosed, and she was advised to enter the hospital for operation. In the past history of the patient the only facts of importance were that she had had pneumonia when æt. 14, and several attacks of influenza. On admission, her temperature was 100°, and her pulse 108; she was very thin and looked ill. Slight dyspnœa was present, but no cyanosis. She had slight cough with a little yellowish sputum. On measurement, the right side of the chest was found to be three quarters of an inch larger in circumference than the left. The right side moved very slightly on respiration, and on percussion there was dulness as high as the fourth rib behind in he axilla and in front; from the fourth rib to the apex the note was impaired anteriorly. Over the dull area vocal fremitus was absent. On auscultation, over the greater part of the right side the breath sounds were almost wanting. In the first and second spaces anteriorly pectoriloquy was heard and there were a few moist sounds. On the left side a few rhonchi were heard, but breath sounds and vocal fremitus were normal. The heart apex beat was in the fifth space one inch external to the nipple line. The evening temperature varied from 103° to 102°, but it fell to normal each morning. The patient having been anæsthetised, was placed on her right side—that is, the affected side—and brought near the edge of the table; an exploratory syringe needle was introduced just above the eighth rib, and a small amount of pus withdrawn. An incision about an inch and a half long was made over the eighth rib in the posterior axillary line; the tissues were divided down to the bone and the periosteum stripped off the rib by means of a periosteal elevator; the bone was divided by cutting forceps, and about an inch was removed; the pleura was then incised, but many adhesions were present and it was not until some of these had been broken down by means of the finger passed upwards that the empyema was opened. About a pint of pus was evacuated. A large empyema tube was inserted, and a pad of gauze and wool applied. Mr. Evans said that in all probability this would prove to be a case of pneumococcal empyema, for the patient had had a very definite attack of pneumonia about a month previously, and, moreover, no tubercle bacilli had been found in the sputum. If this were so the prognosis would naturally be much better than if the empyema had resulted from pulmonary tuberculosis, as was so often the case. The bacteriological examination of the pus would probably clear up this point. The question of the best treatment of empyema was not so simple, he considered, as it was often thought to be. It seemed fairly certain that simple aspiration was practically never sufficient in itself. Some cases had been described in which aspiration apparently sufficed, but certainly in the great majority of cases it needed to be followed by other operative measures. Occasionally simple incision of the thoracic wall between two ribs was sufficient, but this chiefly happened in those cases where the quantity at first was not great, or where the empyema was of very recent origin, so that the lung was in no way fixed by adhesions and was able at once to resume its former size and position when the pus was withdrawn. If however, the purulent effusion was of longer duration, so that the lung had become thoroughly collapsed and contracted close to the spine, the cure of the empyema could only be effected by the falling in of the chest wall. As the chest wall falls in the ribs approximate to one another with the result that the opening made between two ribs becomes greatly narrowed, and any drainage tube placed therein is blocked. Therefore, in cases such as these, it was essential that a piece of rib should be removed. If this is done, most empyemas will get well; the chest wall falling in and the lung expanding to a certain extent. It was only in very exceptional cases that any more elaborate operation, such as Estlander's, was required, as when the lung was unable to expand in the slightest degree. With regard to the question of drainage, there was no need, in his opinion, for any great length of tube to be employed. It was sufficient if the tube reached just into the pus cavity. The approximation of the pleural surface always occurred first at the most distant part, and there was practically no tendency to pocketing of pus. One other point, he considered, deserved attention: Was it necessary or advisable to wash out the pleural cavity in cases of empyema? It was certainly not necessary, for, if the drainage was satisfactory the patient did quite well without it. Further, it was not advisable, for a certain number of instances had been recorded in which washing out the pleural cavity had been followed by immediate death. It was true that this had occurred in only a small percentage of the cases in which it had been done, but, as there was no real advantage in it, it was not worth while to run the risk. The cause of this sudden death, he thought, was probably attributable to reflex vagal inhibition of the heart, and it was not unlikely that the use of a lotion below the temperature of the body had been the real cause, for he could not see that the introduction of a non-irritating lotion at the same temperature as the pus that had been evacuated could produce any harmful results. The clinical pathologist's report on the pus in this case was as follows:—"Films show many pneumococci; cultures did not grow; probably a pure pneumococcal infection." A large amount of pus was daily poured out, but as the quantity diminished a smaller tube was employed and by the end of a week the discharge of pus had almost ceased. The temperature fell to normal on the evening of the operation day and did not again rise above 100°. The dulness rapidly diminished, and the breath sounds improved. The patient was discharged to a convalescent home twenty-five days after the operation. The wound had completely healed. The percussion note was slightly impaired at the right base behind, but elsewhere it was resonant. Vesicular breathing was heard all over both sides, though the sounds were rather weak at the right base and in the lower part of the right axilla. No adventitious sounds were present. The patient's general condition had much improved; she was gaining flesh. She was seen a month later, and was then perfectly well.

TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD JULY 3RD, 1907.

DR J. O. AFFLECK, President, in the Chair.

DRS. FORD ROBERTSON and DOUGLAS MCRAE showed (1) Rats showing paresis resulting from the action of Bacillus paralyticans brevis. (2) Microscopical preparations from cases of general paralysis, illustrating bacillary injection.

Dr. DAWSON TURNER showed (1) A case of rodent ulcer refractory to X-rays, but amenable to radium. (2) A case of rodent ulcer treated by zinc electrolysis.

Dr. LOGAN TURNER showed a patient successfully treated by X-rays for lupus of the larynx.

Mr. J. W. STRUTHERS showed a case of trigeminal nævus with epilepsy and paresis of the arm and leg on the opposite side to the nævus, such a grouping of symptoms had been described in other cases, and in some of these a nævoid condition of the dura had been present. In this case, however, the dura mater was shown at the time of operation to be healthy, the only abnormality present being some flattening of the convolutions. In cases of congenital trigeminal nævus it was important to give a guarded prognosis, bearing in mind the possibility of the subsequent occurrence of epilepsy or pareses.

Dr. CRANSTON LOW showed (1) A case of mixed infection—syphilitic and trilocular. The patient had various patches of lupus, and also evidences of congenital syphilis. (2) A case of erythema iris. (3) A case of bromide rash, peculiar on account of the amount of scurvy present. The patient was an epileptic and had taken bromide for many years. (4) A case of acnekeloid.

Mr. ALEXIS THOMSON read a paper on

THE MAKING OF A SHELF BELOW THE UNDULY MOBILE KIDNEY.

The principle of the operation had been introduced in America some years ago, but it had apparently not yet been adopted in Europe. He did not propose to enter into a discussion of the cause of movable kidney. If one said that it was due to pregnancy one was met by the answer that well-marked instances occurred both in multiparous women and in men. Tight-lacing, again, had been accused of its production; probably a good deal depended on the level of the constriction; if it was at the natural waist the constriction was below the kidney and would tend to keep it steady; whereas if it was higher up, at the level of the tenth rib, it might tend to displace the organ downwards. He thought that mobility of the kidney was favoured by anything, such as a tight corset, which tended daily to alter the position of the organ. Muscular strains might perhaps act in a similar way through fixation of the diaphragm during the exertion, and a consequent pushing down of the kidney. One thing which was noticeable was that the middle zone of the abdomen—from the lower end of the sternum to the tenth rib—was diminished in size in cases of dropped kidney. The arrangement of the fascia of the kidney was important in connection with displacement of the organ. The transversalis fascia split into two layers, one anterior and the other posterior, and between these the kidney lay. The two layers of fascia were firmly united in the external aspect and at the upper pole of the kidney, but on the internal aspect, and below the lower end of the organ, they were not fused, but were lost on the outer surface of the peritoneum. As a result of this arrangement the kidney lay in a sac of fascia which was closed outside and above, open internally and below. Consequently, displacement readily took place in a direction downwards and inwards. The space below the kidney, between the two layers of the transversalis fascia, was known as Gerota's space, and into this the kidney slipped, as the bowel does into a hernial sac. The new operation, which he had performed on five patients, was analogous to that for the cure of hernia. The abdomen was opened by the gridiron method; the kidney was replaced, and the two layers of the fascia below its lower pole were united by a row of sutures so as to prevent the kidney from slipping down between them. The operation had the immediate advantage over nephropexy of not being followed by the nausea, vomiting, and discomfort which stitching the kidney often produced, while the ultimate result, as regards immobility, had been very satisfactory. When there was much displacement it was best to open Gerota's space from outside the ascending colon, so as to get better access for stitching. He did not think that sudden violence could produce prolapse of the kidney into Gerota's space. As to the reason for the right kidney being so much more frequently affected than the left, the liver, of course, had been blamed for it. But in prolapse of the liver the organ rotated forward, so that it was difficult to see how it could displace the kidney downward, seeing that it only came into relation with the latter organ by its posterior part. It seemed more likely that abnormalities in the mesenteric attachments of the ascending colon played a part in the mechanism of movable kidney.

Mr. COTTERELL said that one reason why cases so often relapsed after nephropexy was that patients were allowed to get up too soon, before the recent adhesions had time to become firm. He thought that the main thing was to get the kidney into its proper position, and to keep it there for six weeks. He did not think stitching had much value; his method of operating was to plug the space between the fascia below the kidney with a large quantity of gauze, and to keep the patient in bed for a much longer time than usual after operation.

Dr. WATERSON discussed the anatomical relations of the kidney, and suggested as a possible explanation of the persistence of Gerota's space the large size of the fœtal kidney.

Mr. STILES thought the new operation promised well; he suggested combining the method of making a shelf with nephropexy.

DRS. FORD ROBERTSON and DOUGLAS MACRAE read a paper on the

TREATMENT OF CASES OF GENERAL PARALYSIS AND TABES DORSALIS WITH VACCINES AND ANTISERA.

They first referred to their previous observations on the organisms of general paralysis and tabes, and to the conclusion they had arrived at that two varieties of diphtheroid bacillus, named B. paralyticans longus and brevis, were the specific cause of the disease. This conclusion was based on the constancy with which these organisms were found in cases of general paralysis, and on the fact that animal experiment gave both symptoms and pathological appearances as characteristic of general paralysis. In preparing a vaccine sterilised cultures were used and these had been tested in eight cases of general paralysis and one of tabes dorsalis. There was usually some local reaction, and general symptoms—rise of temperature, leucocytosis, and an exacerbation of the physical and mental symptoms—which was followed by a period of more or less prolonged remission. Notes of the cases so treated were read. In the single case of tabes healed, the vaccination caused some local irritation, which was followed by lightning pains. Repetition of the vaccination, however, had resulted in considerable improvement, and had abolished the attacks of lightning pain for the time. After attaining this success with vaccines, they had tried to produce an antiserum, using sheep for the purpose. They tested the effect on the sheep by noting the bacteriolytic power of the corpuscles. At first this power was possessed by the corpuscles only to a very slight degree—0 to 4 or 6, but after repeated inoculation it rose to 70 or 80. The serum was then withdrawn from the jugular vein with antiseptic precautions, and could be kept for a considerable time. They had administered it to general paralytics by the nose, mouth, and hypodermically. Given by the mouth it was liable to produce nausea and vomiting. Hypodermically, it caused a variable amount of irritation. The general symptoms were a rise of temperature (in 17 out of 24 cases) with increase of inco-ordination, tremor, and mental confusion. Thereafter there was great amelioration of the symptoms. The antiserum had been tried in 24 general paralytics in all; in 10 out of 12 under their personal observation there had been very marked benefit, and in 3 out of 5 partially under their own care. In other cases of insanity of various types no reaction, and no change in the symptoms were produced, while in general paralysis other antisera (diphtheria antitoxin and anti-streptococcus serum) had produced no reaction. Apart from its curative or beneficial effect, therefore, they ascribed considerable diagnostic value to the serum, the febrile reaction which followed its injection being strongly in favour of the existence of general paralysis. Their conclusions were (1) that their antiserum was really diagnostic of general paralysis; (2) that in most cases it caused an improvement of the symptoms; (3) that a polyvalent serum, made from several strains of the diphtheroid organism would probably be more efficacious. (4) That the bacilli were very apt to lose their virulence, and hence it was difficult to obtain a really active serum; (5) that having prepared this anti-bacterial serum they were in hopes of obtaining an antitoxin.

Dr. **GEORGE M. ROBERTSON** read a paper on

THE PRESENCE OF A BACILLUS (MUIRHEAD'S BACILLUS) IN THE BLOOD OF PERSONS SUFFERING FROM GENERAL PARALYSIS, AND OBSERVATIONS ON THE BACILLUS PARALYTICANS.

Dr. Robertson first criticised Ford Robertson's conclusions concerning the bacillus paralyticans, on the ground that the identity of this organism was not established, and that the information given concerning it was too vague to allow of its recognition; he also alluded to the possibility of terminal infection as invalidating the significance of its discovery post-mortem, and the complexity of the flora of mucous membranes in general as a reason for being very cautious in drawing conclusions from organisms found on such sites. The observation made at Larbert had been begun with the view of confirming Robertson's researches, and the observers had confined themselves to trying to find an organism in the blood and cerebro-spinal fluid of cases of general paralysis. They had found in the blood a bacillus of the Xerosis group of diphtheroids on 15 separate occasions in 7 out of 13 cases of general paralysis. From the precautions taken he was satisfied that it was not due to any contamination. The organisms grew on agar plates, but inoculation experiments had not been successful. In order to distinguish it from the Bacillus paralyticans, and to avoid the assumption of any theory as to the part it played in the ætiology of general paralysis, they had named the organism "Muirhead's diphtheroid," after the asylum bacteriologist. They had thus failed to confirm Ford Robertson's work, never having found the bacillus paralyticans longus, and the bacillus paralyticans brevis only once, post-mortem, in association with a leptothux, circumstances which supported the idea that it was due to a terminal invasion.

Dr. **CLOUSTON** spoke of the very remarkable improvement he had noticed in the cases of general paralysis treated by the antiserum. They were all well-marked, definite examples of the disease.

Dr. **BRUCE** confirmed Dr. McRae's statement that the reaction was of diagnositic value; he doubted the pathogenic nature of Dr. George Robertson's organism, and stated that he had made many attempts to grow bacilli from the blood of general paralytics, which always failed. Dr. Robertson's success in half his cases made him (Dr. Bruce) suspect there must be some contamination.

Dr. **LAWSON** said that one difficulty in accepting the reaction as pathognomic was the absence of control experiments on normal persons; he also hoped the investigators would try to standardise their antiserum.

In his reply, Dr. **FORD ROBERTSON** said that the organism he had received from Dr. George Robertson did not give the same cultural reactions as the latter had found, and he did not think it was specific.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, July 7th 1907.

THE TREATMENT OF METRITIS.

THE treatment of the different forms of metritis is a complex problem, and frequently the practitioner hesitates, says Professor Soubeyran, by reason of the multitude of the means employed and their imperfect indications.

On the one hand the treatment should be directed against lesions of the inflamed mucous membrane (acute and chronic metritis) whose glands are hypertrophied and secrete abundantly lesions which can invade the interstitial tissues which are accompanied frequently with vascular dilatations, bleeding with the greatest facility (hæmorrhagic form).

On the other, all kinds of lesions of the os, ulcerations, polipy, rents, frequently complicated with a bad constitutional condition of the patient.

The treatment showed at first prophylatic, consisting mainly in avoiding the two great causes of genital infection: gonorrhœa and puerperal inflammation. Consequently all cases of vulvo-vaginitis and hæmorrhagic bartholinitis should be treated with care, and the husband still suffering from chronic gonorrhœa should be warned of the danger his wife is exposed to.

Puerperal infection should be treated by the ordinary means of asepsy and antisepsy at the moment of delivery or of miscarriage, and if there is retention of the debris of the placenta prompt action should be taken before the hæmorrhage has shown that the infection has already spread to the mucous membrane.

As soon as the temperature has reached 100 F., according to the principles of Pinard, an intra-uterine injection should be made.

Permanganate of potash, gr. 15,
Water one quart.

After this injection, if the temperature has fallen below 100 F., another should be given.

If the temperature exceeds 100 F. with a pulse of 120, large irrigations should be made with 10 or 12 quarts of liquid, and repeated three times daily: water, one quart; permanganate of potash, seven grains.

If, in spite of all this, the fever persisted, a curettage will be necessary, preceded by digital curage or the use of the brush.

These different means, however, should not be used until after the third day of delivery.

All the varieties of metritis require general treatment, hydrotherapy, dry rubbing, cod liver oil, arsenical or ferruginous preparations.

Constipation should be attended to as it produces congestion of the pelvis.

The patients should keep the horizontal position during the acute periods, and wear an abdominal belt, avoid fatigue, all effort and coiters.

The vaginal injections should be given very warm (F. 104 or 112), and taken in the recumbent position.

Acute Metritis.—Here all attempts at exposing the uterus should be avoided. Ice will be placed on the abdomen, or cold compresses; or, on the contrary, poultices on which are scattered a few drops of laudanum; suppositories of belladonna and opium will be prescribed, with hot vaginal injections and warm drinks. When the acute period has passed intra-uterine injections will be necessary at F. 104° every day, with a solution of permanganate of potash (seven grains to the quart). The speculum is introduced gently, the current dilator of Reverdin placed in the os. After the injection a plug of iodoform gauze is left in the vagina.

Once the gonoccocus has disappeared, injections of corrosive sublimate (five grains for a quart) should be made, and the interior of the uterus cauterized with a solution of nitrate of silver (1-50).

Chronic Metritis.—(Leucorrhœa, pain, inflammation of the cervix, &c.). In the ordinary catarrhal form, accompanied with hypersecretion of the glands extending sometimes to the cavity of the uterus, the general treatment should not be neglected, but vaginal antisepsy should be insisted upon. The essential point in the treatment is to arrive at modifying the mucous membrane by intra-uterine therapeutics.

The intra-uterine treatment is effected by three modes of procedure : intra-uterine dressings, cauterizations, curettage.

Naturally, dilatation of the cervix should precede the manœuvres when it is narrow. In the case of a woman who has had several children it is generally not necessary. The dilatation can be made by either the slow or rapid process. The former has the disadvantage of producing great pain and sometimes inflammation. For the latter the bougies of Hégar or the dilators of Sims, Clin or Réverdin, preferably the latter, for it allows dilatation of the orifice under a stream of warm water.

Irrigation of the uterus follows, after which a solution of corrosive sublimate or of nitrate of silver (1–100) is injected.

GERMANY.

Berlin, July 7th, 1907.

At the Medizinische Gesellschaft, Hr. Marmorck, a.G., introduced the subject of

The New Tuberculosis Investigation.

He had studied the early stages of the tubercle bacilli, and had made this the starting-point for his inquiries. The bacillus, in the course of two or three days, formed an exceedingly fine pedicle on the agar and also showed different tinctorial properties from the adult.

These early forms were injected into the abdominal cavities of mice after they had been washed with a solution of hydrochlorate of quinine, which served to paralyse phagocytosis and to make the animals experimented on more receptive. Treated in this manner the bacilli showed that their virulence was very slight.

In experiments on guinea-pigs, it was shown that animals springing from tuberculous mothers were more receptive to tuberculosis than those from healthy ones. In older animals the receptivity diminished.

It was by inoculation with these slightly virulent bacilli that the speaker obtained his serum.

If this attenuated virus was given to animals and tuberculin injected at the same time, in the first instance the upper part of the lungs became diseased. The administration of tuberculin also excited the toxine action, and favoured the development of cavities in the lungs. It was therefore in a position to activate weakened bacilli, which, without the simultaneous action of the tuberculin would not have been strong enough to set up tuberculosis. If the weakened bacilli were injected arterially, they did not set up tuberculosis, and when injected into the veins, at the most a slight attack of the disease.

On the other hand, tuberculosis serum injected into the veins acted much more energetically than when injected subcutaneously or intraperitoneally, and it should perhaps be injected into the vein in cases of tuberculous meningitis.

He then went on to speak of the employment of tuberculosis serum in the human subject, and formulated the requirements that were demanded in such a serum, and claimed that they were all fulfilled in his own serum. An important advantage in the employment of the serum was the fact that it could with propriety be administered by the rectum.

Hr. v. Pinquet, Vienna, had made vaccination his starting-point. After the first inoculation, immunity was induced, but it was not quite absolute. After every re-vaccination, also, a reaction arose, which, however, ran a different course as to time and was milder than the first vaccination.

If children were inoculated in the skin with tuberculin, with a vaccination lancet, there arose a small papule at the inoculation spot so soon as the children became tuberculous; this remained for about eight days and developed in twenty-four hours.

In a large number of children with tuberculosis clinically determined, this reaction took place. It only remained absent in children with miliary tuberculosis and tuberculous meningitis, and in very cachectic children.

Adults almost all reacted to this inoculation, which corresponded to the fact that the majority of hospital patients of large towns were infected with tuberculosis.

Hr. A. Neumann had treated sixteen children with surgical tuberculosis, and two adults with Marmorck's serum, and mostly by the rectum. Children received 1 to 5 ccm. daily for three weeks, adults 5 to 15 ccm. They were all severe cases. Not one showed any improvement that could not be attributed to other therapeutic measures. No injury certainly was done by the serum ; when injected into the veins also it set up no infiltration, nor did it act visibly on the general condition. He must believe, however, that it was not without effect, for the reason that during the treatment patients lost 2 lbs. to 3 lbs. in weight, which, however, they quickly recovered. Only one child increased in weight during the treatment. On the whole it appeared so harmless that patients could go about whilst it was being carried on.

Hr. Van Düren reported that no accidental complications, infiltrations, urticaria, &c., appeared when the serum was given by the rectum. The patients improved in their appetites and gained in weight. Pains ceased and secretions from fistulæ became less, and they slowly closed.

Hr. Landau and Hoffa also spoke favourably of the treatment by Marmorck's serum.

AUSTRIA.

Vienna, July 7th, 1907.

Spondylitis Infectiosa.

Schlesinger exhibited a patient to the members of the Gesellschaft with spondylitis, the result of Dengue fever, which the patient contracted in Egypt last year, but left that country about the month of October and came to Europe in the hope of recovering from the devastations of the sequelæ.

This fever commences innocently with yawning and lassitude, followed by severe pains in the joints, gradually increasing till the patient is laid prostrate in febrile agony. In a short time a remission ensues, with an exanthematous and desquamation lysis. The prognosis in most cases is good, but in the patient before the members, after many remissions, a complicated central nerve disease appeared, which from all appearance was an encephalo-myelomeningitis. After lying three weeks unconscious the patient gradually improved, though the recovery was slow, before being able to walk, when he resolved on coming to Europe seven weeks ago, so runs Becker's report who attended the patient in Cairo.

When he was received by Schlesinger in Vienna he was suffering from a painful form of kyphosis in the lumbar region, evidently developed on the journey thither. There was patella and right foot clonus on examination, but no trace of tubercle could be detected anywhere, neither could any hereditary blemish or other congenital weakness be detected. This new development seems to have been the result of the febrile poison, and therefore of an infectious character, as shown by Quinke in his case of spondylitis. This opinion has been confirmed by the improvement that had taken place since his residence in hospital. One milligramme of a tuberculin solution was injected on admission, but no reaction took place, neither locally nor constitutionally, eliminating tubercle in the diagnosis. This poisoning of the nerve system is not an isolated condition, as we meet with it in typhoid, influenza, &c., and it is reasonable in Dengue.

Atoxyl and Syphilis.

Zeissl next presented a patient that he had treated with atoxyl for syphilis as an example of others who had benefited by its administration. He would not dogmatise on the efficacy of the drug in this particular disease, but from the results he had obtained he was of opinion that the drug had some special virtue in this disease. It certainly retained the strength of a weak luetic patient where mercury and iodates would be injurious.

DIAGNOSIS OF TUBERCLE.

Pirquet presented a six months' child on whom he had performed the "Allergie" test for tubercle with a positive result. The child was received into hospital on the 12th of June suffering from an eruption on the right cheek of a doubtful character. The scab covering the sore was about five centimetres across, with a red swollen margin—the scab being yellow and black. Scattered around in the neighbourhood were a number of white tubercles, several of which were as large as beans with enlarged glands below the angles of the jaw. These tubercles also became purulent and formed scabs which, when removed, left depressions in the tissue with red efflorescent edges. Lungs, heart, and all the internal organs were healthy—no other pathological change could be discovered, unless this tubercular ulcer on the cheek, which seems to have been the primary sore causing the swelling in the regionary glands.

Now came the crucial point of determining whether this is tubercle or not. At this age tuberculin rarely acts positively, and thus tuberculoids are resorted to. Both of the arms were inoculated below the elbow, while the control was watched by a simple scratch, Around the surface (twelve millimetres), where the tuberculin was inoculated, papules presented themselves, while the simple scratch remained free.

HIRSCHSPRUNG'S DISEASE.

Schnitzler presented a child, æt. 3 years, on whom he had performed resection of the sigmoid flexure. He recommends Hirschsprung's bilateral operation for the disease as the most satisfactory.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE ASSAULT ON DR. CARSEWELL, GLASGOW. —THE QUESTION OF INSANITY.

DR. CARSEWELL'S assailant was tried before the High Court of Justiciary in Glasgow on July 2nd. Evidence was given as to the purchase of a revolver and cartridges by the prisoner a week before the assault was committed. When making the purchase the accused asked if the weapon would kill a man, and tested it by firing into some empty boxes. Eyewitnesses then told the story of the assault. After the accused was arrested he said he did not mean to kill the doctor, adding: "Do I look like a murderer?" He continued that he was justified in his act, and had committed it to protect himself and the public. His object was to get Dr. Carsewell brought before the public in a witness-box. Medical evidence was given concerning the extent of Dr. Carsewell's injuries, and then to the effect that the prisoner was of unsound mind His Lordship (Lord Maclaren) at this stage remarked on the exceptional course being taken by the defence. It was not attempted to prove that the prisoner did not commit the act charged, and instead of taking the usual course of trying to show that the accused is insane, the attempt was to prove that he was perfectly sane, while the prosecution was seeking to prove the opposite. The prisoner's counsel said his plea was that the accused deliberately shot at Dr. Carsewell with the purpose of bringing his case, having failed by other means, before the public. He was, however, careful not to do him serious harm, and he had pleaded not guilty under the notice that the real question at issue was as to his sanity, and his object was to prove before all else that the prisoner was perfectly sane. The view the Crown took was that the man was dangerous as a subject, and that the proper method was to treat him as a criminal lunatic. Medical testimony having been given as to the prisoner's sanity, he was then examined on his own behalf. He described how proceedings were taken without his being aware of their object, by Dr. Carsewell and Dr. Gilchrist, which resulted in his being certified as insane, and placed for some months in an asylum. He knew that while in that institution, if his wife had consented to his being liberated, he could have got out. After he did come out he raised an action against his medical attendants for wrongous certification. Failing by that means to attain his object, he tried every other legitimate means he could think of, and having failed in all these and lost all his money in the endeavour, he had taken this last course as the only one left of having this case brought before a jury of his fellow countrymen. He considered his grievance a violation of public liberty. After an absence of ten minutes the jury returned a unanimous verdict of guilty, but without intent to do serious bodily harm.

His Lordship then passed sentence of seven years penal servitude. He considered it a very serious offence. He quite believed the prisoner did not mean to kill the doctor, but he could take it from no man that he fired shots into the body of a fellow-creature not meaning to do him serious harm. He had made the sentence as light as he could.

Apart from the interest which the circumstances leading up to the assault lend to this case, the trial is remarkable as another instance of the peculiar relationship of insanity and criminal responsibility to the law. As in the New Cumnock poisoning case, the Crown tried to prove the prisoner insane, a plea which, if successful, would have barred a verdict on the facts. The evidence was to the effect that the accused suffered from delusional insanity arising from a mental deterioration quite consistent with general intelligence, and also (in the opinion of defender's witnesses) consistent with an appreciation of right and wrong, and the legal consequences of his actions. The question of insanity barring a verdict on the facts was duly laid before the jury, and it is interesting that the commonsense of the jurors very quickly arrived at the conclusion that, despite his delusions, the prisoner was responsible—in a word, the layman's position was, as we think, behind that which medicine has for long, and the law for a shorter time, tended to take up. Possibly the jury shrank from admitting the principle of an extension of mental irresponsibility, when they knew that the view of the Crown was that this would carry with it permanent incarceration in an asylum. The public mind is evidently not prepared to have everyone whom an expert declares irresponsible placed under control. From a medical point of view, however, there seems strong reason to believe that the contention of the Crown was right. The prisoner was certified as insane (and correctly certified as insane, for he failed absolutely, despite the best efforts of leading counsel, in obtaining a verdict of damages for wrongous certification), and subsequently committed a premeditated, serious crime, "to bring his case before the public." It is admitted that he suffers from mental deterioration with delusions. Who can doubt that he is a fit subject for asylum treatment? Yet by the action of the jury he is sent to penal servitude.

BELFAST.

THE CORPORATION AND THE LOCAL GOVERNMENT BOARD.—At a recent meeting of the Public Health Committee of the Corporation it was reported that a small deputation from the Committee had waited on the Local Government Board with reference to several matters recently under consideration. The deputation brought before the Board the necessity that exists for the committee obtaining fuller details of the deaths in the city, with the name and residence of the deceased, and the cause of death, so that more efficient action might be taken in the case of death from infectious disease. This information in the case of Dublin is supplied by the Registrar-General, and there seemed no reason why Belfast should not be given similar aid. The Board replied that they considered it the duty of the Registrar-General to demand from the local registrars a copy of all deaths registered by them, and the proper course was to approach the Registrar-General and obtain this information, which it was most important to have.

LETTERS TO THE EDITOR.

PROPOSED ROYAL COMMISSION ON CANCER.

To the Editor of The Medical Press and Circular.

Sir,—The excuse given by the Prime Minister for refusing to appoint a Royal Commission to enquire into the subject of cancer, was, to say the least, a very lame one—"he was advised that much remained to be done before any facts could be brought before a Royal Commission with any likelihood of their making such an enquiry fruitful for the public advantage." At any rate, this objection could not possibly apply should a Royal Commission be asked for with regard to quackery, now more rampant than ever, and producing quite as much harm as the spread of cancer itself. I trust this agitation in favour of a Royal Commission to enquire into the evils of quackery, patent medicines, &c., will not be allowed to fizzle out, but that before long public opinion will insist on such enquiry quite as necessary as that with regard to cancer.

I am, Sir, yours truly,
Alexander Duke.

London, W.

QUACKERY AND PRACTICE BY COMPANIES.

To the Editor of The Medical Press and Circular.

Sir,—Lord Hylton's Bill was read a third time and passed in the House of Lords on Wednesday last. It will now be sent down to the Commons; and those who care may believe that it will be accepted by the Lower House, and in due course find a place in the Statute Book. Since I last wrote on this subject, I have had the opportunity of seeing the full notes of the evidence given before the Lords' Committee, and I am not at all surprised to find that Dr. Heron, Chairman of the London and Counties Medical Protection Society, and Dr. Bateman, Secretary of the Medical Defence Union, express precisely the same opinion that I have twice put forward in your pages, namely, that the Bill is useless as a blow against quackery, and that at the best it could only put to temporary inconvenience the very small percentage of impostors who make use of the Companies Acts as a cloak for their nefarious games. It is amusing to note that the promotors of the Bill had to stand on the defensive, and to show that the legitimate (?) interests of unqualified quacks would not be interfered with by the proposed legislation. If, on the other hand, a Royal Commission such as I advocate, had been sitting, the case against the quacks of every denomination would have been stated, and these gentry had they dared to put in an appearance, would have been obliged to undergo cross-examination by counsel. In my letters so far I have not referred separately to the case of the dentists. It would be easy to prove before a Commission the injury to the public from quack dentistry. The quack's bait—artificial teeth at prices which would not pay for the work if the operations could be reduced to a mere mechanical routine, which is, of course, impossible—attracts mostly simple and foolish women. Virtually, they never get teeth at the prices promised. They are supplied with teeth of the most inferior make, and the remaining diseased teeth and roots are invariably left without the necessary treatment. As a result, in a vast proportion of cases, a septic condition of the mouth is kept up which is often enough seriously to affect the general health, and even to form a contributory cause towards a fatal termination of an existing malady. The quack dentist is only less harmful than the quack doctor because his scope for mischief is more limited.

I am, Sir, yours truly,
Henry Sewill.

Cavendish Square, July 4th, 1907.

IS ENGLISH LOCAL GOVERNMENT A FAILURE?

To the Editor of The Medical Press and Circular.

Sir.—In spite of the recent scandal of criminal convictions, we find that at last week's election of a new Board of Guardians for West Ham, only 15 per cent. of the burgesses recorded their votes. On previous occasions you have allowed me to point out that similar apathy prevails as a rule throughout the land, in urban and rural districts alike. Local governing bodies have practically complete control of the sanitation of their districts, and are, besides, now the directors of education. All our State institutions are, in fact, democratised, and it is certain that unless the great bulk of respectable and responsible citizens will take due interest in their working—unless they will accept office themselves or take at least an active part in getting proper representatives to serve—maladministration and corruption will appear. These local bodies have in their hands the appointments of medical officers under the Poor Law, and Public Health Acts, and it is impossible to expect any real improvement in the present deplorable status of these officers so long as local bodies continue to be largely made up of ignorant and vulgar men, whose object very often is to obstruct the administration of laws which conflict with their own sordid interests. The extreme developments consequent upon the lack of true patriotism in the citizens of a democratic society are now being sufficiently illustrated in the United States. It seems that the same dangers exist at home, and if the spirit of our people cannot be roused we must be prepared in the end for national disaster. This pessimistic forecast will not be deemed exaggerated by serious students of the sociological phenomena of the present day.

I am, Sir, yours truly,

July 1st, 1907. M. O. H.

VOYAGE D'ETUDES MEDICALES.

To the Editor of The Medical Press and Circular.

Sir,—May I call the attention of your readers to the facilities for seeing certain of the French health resorts which are annually offered by the organisation which bears the above title? For the purposes of these visits, France is divided into five districts, each of which contains a large number of spas and mineral-water stations. Every year one of these districts is made the object of a carefully arranged inspection. The time chosen is the first fortnight in September. The party, which is strictly limited to 100 persons, travels under the most favourable conditions. A first-class special train conveys the members from place to place. The hotel accommodation and the food is provided for in advance. The care and transport of the luggage is undertaken by the organisers in such a way that a member's valise left at the proper hour outside his bedroom at the place of departure, is found inside his bedroom at the next halting-place. The advantages of the particular stations visited are explained at each place by Professor Landouzy, who acts as the president of the company. This year the health resorts to be visited are those in the district of the Vosges, which include such well-known places as Contrexéville, Vittel, Martigny, Plombières, Luxueil, and many others. The *rendezvous* is at Reims on August 31st, and the company parts at Divonne, on the Lake of Geneva, on September 13th. Having now taken part in five of these trips, I can assure your readers that there is no more agreeable or instructive manner of spending a part of one's summer holiday. The price (300 francs, or £12) is astonishingly low, especially when it is realised that this includes everything from the *rendezvous* to the *dislocation*. There are no tips or extras of any kind. Medical men and their wives, and medical students, are allowed to join. Those coming from this country are always sure of a particularly warm welcome.

I shall be happy to supplement this information if any of your readers should desire further particulars on the subject.

I am, Sir, yours truly,
Leonard Williams.

8 York Street, Portman Square, W.

OBITUARY.

WILLIAM SCOTT, M.D.Edin., L.R.C.P.Edin.

We regret to record the death on July 2nd, at the age of 78 years, of Dr. William Scott, of Huddersfield. From September last the deceased gentleman had been in indifferent health, and he died from heart failure following passive congestion of the lungs.

Dr. Scott was born at Hexham, and was educated at Newcastle and Edinburgh University. He took the degrees of M.D. and L.R.C.P. in 1860. He afterwards became assistant to Dr. Ramsbotham, at Huddersfield, whose practice he took over at the death of that gentleman. Many years ago he took into partnership Dr. Thornton, of York Place, Huddersfield, and the practice became a very extensive one. Forty years ago he was well known in cricket circles as a good batsman, and played many times against touring All-England elevens. He was one of the founders of the Huddersfield Gentlemen's Club. In politics Dr. Scott was an ardent Liberal, and he was a vice-president of the Huddersfield Liberal Club, but he took no active part in public life. He was a Congregationalist and attended Highfield Chapel, Huddersfield. He leaves two sons and two daughters.

ROBERT SETTLE, M.D.Glasg.,L.R.C.S.Ed., L.S.A., V.D.

We regret to announce the death of Dr. Robert Settle, of Bolton, who passed away last week at the ripe age of 82. He studied medicine at Dublin and at Glasgow, and graduated M.D Glasg. in 1849. Subsequently, he took the L.R.C.S. of Edinburgh, and the L.S.A. of London. He was a native of Bolton, and he practised in that town for sixty years, and held many public appointments. He was an ardent volunteer, and till lately held a commission as Surgeon-Major in the 2nd V.B. Loyal North Lancashire Regiment. He was awarded the volunteer decoration for his long and faithful service. Shortly before his death he resigned the post of Medical Officer and Public Vaccinator to the Bolton Union. He was also Honorary Consulting Surgeon to the Bolton Infirmary and Certifying Factory Surgeon for his district.

CHARLES LATHAM, M.R.C.S., L.S.A.

We regret to record the death at Sandbach, of Dr. Charles Latham, in his 91st year. Dr. Latham had held many public appointments in the district, and was once a famous cricketer. Last year, on the attainment of his 90th birthday, he was presented with a wedding cake with a representation on the top of a bat, wicket and ball, and the inscription, "90 and not out." He qualified M.R.C.S. and L.S.A. as long ago as 1839.

THE LATE DR. E. H. BENNETT.

Referring to our obituary notice of Dr. E. H. Bennett "a colleague and friend" sends us the following note, which we have pleasure in publishing:—By the lamented death of Dr. Edward H. Bennett, Irish Surgery has lost one of its most accomplished representatives, and a link between the present and the past generation has been severed. He was a man of sterling qualities, and had a wide reputation for his intimate knowledge of surgical literature, which freely permeated all his teaching. Although he did not attain to a very extensive practice, nor was he a brilliant operator, he was an acknowledged expert in several branches of surgery, notably in the domain of fractures and dislocations, and his opinion as a consultant in this department was often sought by his professional brethren, and always carried weight. In manner sometimes a little brusque, he was one of the most kind-hearted of men, and few teachers have enjoyed greater popularity with medical students, a class quick to recognise genuine merits. Socially he was a genial host, and excellent companion, and his unfailing good temper carried him serenely through life, and enabled him to meet a trying and prolonged illness with fortitude.

His knowledge of anatomy was sound and accurate, and for many years he filled the post of University Anatomist in the School of Physic, T.C.D., where he conscientiously trained a large number of students.

The writer of this note well remembers the first "demonstration" he received from Dr. Bennett, who unfolded to him the mysteries of the inguinal region, and the perplexing layers of fascia which adorn that region. He was devoted to his work in Sir Peter Dun's Hospital, and it is largely due to his unsparing attention and zeal that the surgical reputation of the Hospital was securely established at the critical time—now many years ago—when it was transformed from a purely medical hospital to a fully equipped Medico-Chirurgical Hospital.

SPECIAL ARTICLE.

IMPERIAL CANCER RESEARCH FUND.

The annual meeting of the general committee of the Imperial Cancer Research Fund was held at Marlborborough House, on Monday, July 1st, H.R.H. the Prince of Wales in the chair. Among those present were Sir William Church, Sir Richard Douglas Powell, Mr. Henry Morris, Sir Henry R. Swanzy, Sir Henry Howse, Sir John McFadyean, Dr. John Tatham, Dr. Rose Bradford, Mr. H. T. Butlin.

The annual report of the Executive Committee described the proceedings of the fifth meeting of the General Committee, held on July 25th, 1906, under the presidency of Lord Strathcona. The General Superintendent took part in a discussion on cancer at the annual meeting of the British Medical Association, held in Toronto, last August. He subsequently proceeded to the United States, and visited many of the important laboratories, including the Rockefeller Institute, in which cancer investigation is being carried out.

In September Dr. Bashford also attended, as the representative of the Imperial Cancer Research, the German International Cancer Congress, held in Heidelberg and Frankfort, of which he was elected one of the Honorary Presidents. Whilst in Germany he was able to obtain a valuable interchange of views with Professor Ehrlich and others engaged in the investigations on cancer.

Since that meeting a communication had been received from some of the German representatives proposing the establishment of a permanent international conference on cancer, and forwarding an outline scheme of organisation, with its headquarters in Berlin. The General Superintendent was asked to organise a British branch and to become one of the representatives, but he was of opinion that at present little advantage was to be gained by such a conference.

The General Superintendent and staff had been continuously engaged in investigation, and a considerable number of new facts had been ascertained. They were not, however, yet ready for publication in the form of a third scientific report. The progress of the investigations was recorded in the papers from the laboratory.

A grant had been made to Mr. W. Sampson Handley towards the expenses of an investigation into the mode of growth and dissemination of cancer of the stomach. The Government of Cape Colony had forwarded an important report of a Committee of the House of Assembly appointed to investigate certain reputed cancer cures, principally consisting of herbal remedies. Dr. Sidney Martin, F.R.S., had been re-elected a member of the Executive Committee by the Royal College of Physicians. Sir John Tweedy and Mr. Edmund Owen had been elected by the Council of the Royal College of Surgeons to fill the vacancies on the Committee occasioned by the expiration of Mr. John Langdon's period of office on the council, and by Mr. Henry Morris becoming *ex-officio* a member of the Committee, in virtue of his appointment as President of the Royal College of Surgeons, whilst Mr. Henry T. Butlin was also re-elected a member of the Committee by that College. Dr. Rose Bradford was again nominated by the Royal Society as their representative on the Committee, The Committee once more expressed its appreciation of valuable services rendered by the Foreign, Colonial, and India Offices in obtaining and forwarding information relating to cancer throughout the Empire.

In December the Committee received from one of the vice-presidents, Mr. H. L. Bischoffsheim, an intimation that he intended to give a donation of £40,000 in commemoration of his golden wedding. This munificent gift, which was warmly acknowledged by the Committee, was particularly gratifying as evidence of the confidence felt by the donor in the efforts being made by systematic scientific investigation to arrive at a more exact knowledge of the nature, causes and treatment of cancer.

The General Superintendent's Report was then read.

Honorary Treasurer's Report.

The report of the Honorary Treasurer for the year ending June 24th, 1907, stated that in August, 1906, the Fund was increased by a donation of £1,000 received through His Royal Highness the President from an anonymous donor. This was followed in December last by the munificent donation of £40,000 from Mr. and Mrs. Bischoffsheim on the occasion of their golden wedding.

The amount in donations and subscriptions received during the year, apart from the Bischoffsheim Fund, was £3,515 11s. This compared favourably with the amount (£2,315 2s.) received during the year 1905-6. Special reference was made to the gift of £600 received through Sir Samuel Wilks, Bart., F.R.S., to the gift of £500 from Miss Black, to the sum of £120 from the Government of Hong Kong, which represents the subscription of £30 per annum for the years 1904-7 inclusive which was obtained through the good offices of the Governor, Sir Henry A. Blake, G.C.M.G. In addition to several fresh donors of varying sums, eight new annual subscribers had been added to the list this year, one of whom was the Worshipful Company of Carpenters. This was the first City company to become an annual subscriber. The Worshipful Company of Pewterers had, however, given a third donation. At the present time there were eighteen annual subscribers. The Fund was still deficient to the extent of nearly £13,000 on the estimated amount required to provide a sufficient and permanent income from invested capital.

Sir William Church moved the adoption of the report.

Sir Henry R. Swanzy, in seconding the motion, said the thanks of all were due to Dr. Bashford and his assistants for the sustained, well-directed and skilful efforts made by them to solve the many problems surrounding the subject of cancer. Substantial progress was being made, and they believed that nothing which scientific skill could devise was being omitted to solve this problem.

The resolution was carried unanimously.

Sir Julius Wernher proposed a vote of thanks to the Chairman and members of the Executive Committee, the Sub-committees, the Honorary Treasurer, the Secretary, Auditor, and others who had assisted in the work of the Fund during the past year. It was sometimes said that the work of the Fund was, perhaps, slow; but very few people recognised the nature of this scientific difficulties which had to be surmounted.

Mr. H. L. Florence seconded the motion, which was unanimously agreed to.

The Bischoffsheim Donation.

Mr. Henry Morris next moved :—"That the General Committee desire to place on record their deep sense of gratitude to Mr. and Mrs. Bischoffsheim for their recent munificent gift of £40,000, which, together with Mr. Bischoffsheim's original donation of £5,000, will do so much towards placing the Imperial Cancer Research Fund on a secure financial basis."

Sir Charles Morrison Bell seconded the motion, which was passed unanimously.

On the motion of Dr. Rose Bradford, seconded by Mr. Ludwig Neumann, Mr. Watson Cheyne was re-elected a representative of the General Committee on the Executive Committee; and on the motion of Mr. Butlin, seconded by Sir John McFadyean, Sir John Tweedy was elected a member of the General Committee.

Sir R. Douglas Powell proposed a vote of thanks to the Prince of Wales for presiding.

Mr. Edmund Owen seconded the motion.

The motion was passed with applause.

The Prince of Wales, in reply, said it was a great pleasure to him to have been able to preside at the meeting. They had every reason to be satisfied with the growing confidence of the public in the work of the Fund. The broad lines of inquiry undertaken by the Imperial Cancer Research Fund, had, they felt certain, influenced the whole nature of investigation at home and abroad. It was recognised that the work was conceived and carried out in a liberal spirit; that whatever facts were ascertained were immediately made known to every one; that the material was freely placed at the disposal of all qualified to use it to good advantage; that their staff was not working for its own ends, but with a whole-hearted desire to help on a solution of the problem. Another tribute to the success of the efforts of the Fund was the number of applications from skilled investigators to take part in the work. Thanks to the liberality of the Royal Colleges, further accommodation had been placed at the disposal of the General Superintendent, and he had, therefore, been enabled to add materially to the staff.

His Royal Highness concluded by expressing his thanks to the chairman and members of the various committees, Dr. Bashford, and the officers of the Fund, for the valuable and untiring services which they had given during the past year to the work of the Fund.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons, England.—Annual Election to the Council: a Record Poll.

The annual meeting of Fellows of the Royal College of Surgeons of England took place last Thursday for the purpose of electing four Fellows into the Council of the College. The President, Mr. Henry Morris, occupied the chair, and appointed Mr. Willmott Evans and Mr. T. Crisp English, who kindly offered their services, to act as scrutineers for the occasion. After the secretary had read the list of candidates, the President declared the poll open for two hours, for the convenience of those Fellows desiring to vote in person. Only fourteen Fellows, however, voted in this manner, no fewer than 878 Fellows recording their votes by post. The poll proved to be a record one. At the conclusion of the counting the President declared the result of the poll to be as follows :—Mr. C. J. Symonds, Guy's Hospital, 452 (26 plumpers); Mr. Wm. Bruce Clarke, St. Bartholomew's Hospital, 413 (52 plumpers); Mr. C. Mansell Moullin, London Hospital, 403 (6 plumpers); Mr. Frederic Eve, London Hospital, 388 (3 plumpers); Mr. H. W. Page, St. Mary's Hospital, 349 (11 plumpers); Mr. W. D. Spanton, Hanley, Staffs, 348 (34 plumpers); and Mr. Charles Higgens, Guy's Hospital, 234 (10 plumpers). The President then declared Messrs. Symonds, Clarke, Moullin, and Eve duly elected members of the Council. The scrutineers found three balloting-papers to be invalid, and three arrived too late.

Society of Physicians and Surgeons of the Society of Apothecaries, London.

The first dinner of this newly-formed society was held in London last week at the Restaurant Frascati, to celebrate the obtaining of the Act of Parliament which received the sanction of his Majesty the King on July 4, 1907, the day of the banquet. This act confers the title of "Licentiate in Medicine and Surgery" on its members, since June, 1887. There were present the President, Dr. Rivers Willson and Lady Willson, the Ex-president, Dr. Percy Lodge, the Vice-president, Dr. McCorner, J.P.

Dr. Parker Young, the Master of the Society of Apothecaries, the Senior Warden, Dr. G. Willes, and the Junior Warden, Dr. F. G. Brown, were the guests of the evening. The representatives of the Society of Apothecaries present were Sir Hugh Beevor, Bart., Dr.

Gerald Dalton (the Hon. Treasurer), and Dr. S. H. Green, Dr. Marsh, Mr. L. Darlington, Dr. Horace Saunders and Mrs. Saunders, Dr. George Brown (late of the General Medical Council), and Mr. M. Upton (Clerk to the Society), and many others.

After the Royal toasts had been duly honoured, the President gave the toast, "The Association of Physicians and Surgeons," introducing in his remarks a *resume* of the work done in the obtaining of this Act of Parliament. The next toast was "The Master Wardens and Court of Assistants of the Apothecaries Society," who had influentially furthered the movement, which was duly honoured and responded to by Dr. Parker Young (the Master). Dr. Geo. Brown gave the toast of "The General Medical Council, and its Reform," Sir Hugh Beevor responding. Then followed "The President and Officers," proposed by Dr. G. W. B. Marsh, who alluded to the founding of the Society some years ago by Dr. Percy Lodge. Dr. Rivers Willson responded, and also made allusion to the good work done by Dr. Lodge, and said that that gentleman had according to the rule vacated the Presidentship on his becoming a Fellow of the Royal College of Surgeons. Dr. Lodge also responded, and said that some six years ago he had the honour of being received by the then Master and Wardens of that Society on these matters, and received much support from Dr. Parker Young and the Court of Assistants. He congratulated Dr. R. Willson, the President, on the good work he had done in his years of office, and that the Society of Physicians and Surgeons had been able to attain so much of the object they had in view. M. and Madame Cokhinis and their son gave a very excellent musical programme during the evening, which was much appreciated.

Royal Army Medical Corps.

At a recent inspection by Col. A. T. Sloggett, C.M.G., Principal Medical Officer of the London District, of the Companies as well as the bearer companies of the 1st, 2nd, and 3rd London Infantry Brigades, numbering about 400, the column was accompanied by an ambulance and transport train of eight wagons, a cyclist section, and a couple of ambulance dogs trained by Major Richardson, who was present with the corps, to which he has been attached. A field ambulance was pitched, and a demonstration was given of carrying patients in cacolets and on horse-back. The inspection was attended by the War Minister, Mr. Haldane, who showed great interest in the programme of work carried out by the troops. Among the other officers present was Col. J. Cantlie, F.R.C.S., the honorary colonel and organiser of the corps.

Royal College of Surgeons, England.—Vacant Examinership.

The period of office of Mr. C. H. Golding-Bird on the Court of Examiners of the Royal College having expired, the Council will proceed to elect a successor on the 25th instant, Mr. Golding-Bird having notified his intention not to seek re-election. A vacancy on the Board of Examiners in Dental Surgery is also announced; Mr. B. Pateman, the present examiner, whose period expires, is eligible for re-election, and will offer himself for the post. Applications for either appointment must be sent in to the Secretary, S. Forrest Cowell, Esq., on or before the 17th instant.

St. John's Hospital for Diseases of the Skin, Leicester Square.

The annual competition for the Chesterfield Silver Medal (which was instituted in 1895, by the Earl of Chesterfield, President of the Hospital) took place on May 24th, and the Medal has been awarded to E. J. D. Mitchell, M.A., M.B., B.C., for proficiency in Dermatology.

Epsom College.

The annual general meeting of the governors of Epsom College took place last week at 97 Soho Square, London, W., under the chairmanship of Mr. Henry Morris (President of the Royal College of Surgeons). Among those present were Sir R. Douglas Powell, Sir William S. Church, and Sir C. Holman. The chairman announced the foundation of the Robert Armstrong scholarship of £60 a year for classics, and of the R. R. Cheyne annuity for the daughters of medical men who are Protestants. Three pensioners and seven foundation scholars were elected, and at a meeting of the council, held immediately after, two pensioners in addition to the foregoing were admitted, vacancies having arisen.

PASS LIST.

University of London.

The following candidates have passed the M.B., B.S. Examination:—

With Honours.—Harold Garfield Bennett, St. Thomas's Hosp. (*a*); Gerald Tyler Burke, St. Barth. Hosp. (*c*); Bertram Walter Cherrett, St. Barth. Hosp. (*e*); John Henry Farbstein, University Coll. (*d*); John Athelstan Braxton Hicks, Westminster Hosp. (*b*); William Henry Miller, Guy's Hosp. (*d*); Henry John Nightingale, St. Thomas's Hosp. (*a*, *b*, *c*, *d*, *University Medal*); Alfred Chas. Foster Turner, St. Thomas's Hosp. (*b*.); Charles Wilfred Vining, St. Mary's Hosp. (*a*). (*a*) Distinguished in Medicine. (*b*) Distinguished in Pathology. (*c*) Distinguished in Forensic Medicine and Hygiene. (*d*) Distinguished in Surgery. (*e*) Distinguished in Midwifery and Diseases of Women.

Ordinary Pass.—Godfrey F. E. Allison, Charles J. Armstrong-Dash, John S. Avery, Alfred Ball, Alec Barber, Tom Bates, Ella Beales, Sylvia R. M. Blackstone, Mary A. Blair, John F. Broughton, Stanley W. R. Colyer, Eustace J. C. Dicks, Kenelm H. Digby, Allan B. Fearnley, John Ferguson, Kenneth M. Gibbins, Elliott T. Glenny, Samuel L. Graham, Arthur D. Griffith, Leopoldine W. D. Griffiths, Sidney W. Grimwade, George Hamilton, Horace B. Hill, Frank N. S. Hitchcock, Frank P. Hughes, Gwilym G. James, Sidney H. J. Kilroe, Herbert S. Knight, Janet Lane-Claypon, D.Sc., Alexander Manuel, Marian Mayfield, Emily H. Morris, Frederic M. Neild, Geoffrey E. Oates, Catherine Payne, August F. Perl, Arthur J. S. Pinchin, John M. Plews, David Ranken, Frank D. Roberts, Cecil F. Robertson, Francis W. Schofield, Henry J. Smith, Ronald E. Todd, James A. Torrens, Stuart W. J. Twigg, Joseph Unsworth, Thomas W. Wade, Norman H. Walker, Thomas E. Walker, Robert J. Waugh, David Wilson, Alfred W. G. Woodforde, Carl E. Zundel.

B.S. Examination (for students who graduated in Medicine in or before May, 1904).—John Acomb, Dora E. L. Bunting, Edward C. B. Ibotson, Rees Phillips, Frank Tratman, M.D., Hilda K. Whittingham.

Trinity College, Dublin.

The following candidates passed the Final Medical Examination (Trinity Term), Part II., Surgery:—William Pearson, Robert E. Wright, Richard G. S. Gregg, Allman J. Powell (passed on High Marks); William E. M. Armstrong, Frederick Stevenson, Henry de C. Dillon, Oliver St. J. Gogarty, Thomas B. W. MacQuaide, Reginald Holmes, Wallace D. Mitchell, James C. C. Hogan, Madeleine S. Baker, Charles H. O'Rorke, James E. M'Farlane, Joseph C. Ridgway, William A. R. Spong.

Final Examination.—Part III.—Midwifery.—Frank R. Seymour, Henry de C. Dillon and William A. R. Spong (equal), William E. M. Armstrong, Robert de C. Wheeler, Arthur E. Knapp, Thomas P. Dowley John H. Waterhouse, Alfred H. Smith.

University of Birmingham.

The following is a list of the successful candidates in the Faculty of Medicine at the examinations held June, 1907:—

Degree of Doctor of Medicine.—Leonard George Joseph Mackey.

Degrees of Bachelor of Medicine and Bachelor of Surgery for Past Students of Birmingham Medical School.—William Frederick Ewart Ashton. *Under Ordinary Regulations.*—Herbert Charles Horace Bracey, *†James Fenton, Philip James Mason, Nevill Coghill Penrose, Arthur Addison Sanders, Arthur John Smith, Rupert Wesley Thompson, Herbert Henry Warren. (*Queen's Scholarship. † Ingleby Scholarship.)

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Mode of Spread of the Meningococcus.—Fraser and Comrie (*Scottish Medical and Surgical Journal*, July, 1907) report the result of their inquiry into the mode of spread of infection during the recent outbreak of cerebro-spinal meningitis at Leith. They are led to agree with the conclusion of Ludwig Jehle that although children most commonly suffer, they are not to any extent carriers of the disease. Jehle, from his investigations during the epidemics in Silesia and in the Rhine coal-fields, suggested that the real carriers of infection in those provinces were miners who, bringing the organisms from an infected pit, passed it on to their children. Substituting dock-labourers for miners, and ship-holds for coal-mines, Fraser and Comrie hold similar views in regard to the recent epidemics at Leith and other sea-port towns in the kingdom. The question has to be decided, however, of the manner in which the meningococcus can be carried without infecting the carrier. Fraser and Comrie examined the naso-pharynx in 13 cases of the disease, and in 69 cases of intimate contact. The meningococcus was present in 2 of the 13 cases (15 per cent.), and in 10 of the 69 cases (14 per cent.). Of the 69 cases, 15 were fathers of affected patients, the remaining 54 being mothers, brothers, sisters, and other intimate associates. Of the 10 contacts in whom the meningococcus was found, 5 were fathers of patients. Thus, while the organism was found in 33 per cent. of the fathers, among others contacts in as close intercourse it was found in only 9 per cent. The fathers appeared, therefore, to be especially prone to have the meningococcus in the naso-pharynx, although they did not themselves contract the disease. Of the 15 fathers examined, 5 were employed in overhauling the same ship; the meningococcus was recovered from the air in the engine-room. In several other fathers the naso-pharynx was found to contain gram-negative diplococci, but owing to the excess of saprophytic organisms isolation was impossible. In the case of 23 controls, who had no connection with the disease, the naso-pharynx was examined for the meningococcus with negative results. Fraser and Comrie summarise their conclusions:—(1) That dusty, ill-ventilated atmospheres, which provide conditions favourable to the growth of the meningococcus and to the occurrence of naso-pharyngeal catarrh, are often associated with the dissemination of epidemic cerebro-spinal meningitis. (2) The high comparative proportion of fathers, whose naso-pharynx was found to contain the meningococcus, suggests that they are the carriers of disease to their children. (3) The chief incidence of the disease in the Leith epidemic was among children of the lower classes, a point in favour of naso-pharyngeal infection. (4) Infection of the naso-pharynx is an important factor in spreading the disease. (5) It is advisable to isolate all contacts, and to carry out a bacterioscopic examination of the nose and naso-pharynx. It should be added that Fraser and Comrie relied for the bacteriological diagnosis of the organism on the characteristics described by Gordon in his recent report to the Local Government Board. R.

Muscular Tuberculosis.—Kirmisson (*Bulletin de l'Académie de Médecine*, No. 6, 1907) and Cornil (*id.*, No. 8, 1907) report cases of this rare condition. In Kirmisson's case, a child, æt. 10, presented numerous fusiform nodules scattered through the muscles of both lower limbs. The glandular system was also widely affected. The nodules were found on microscopic examination to consist of masses of epithelioid and giant cells, embedded in fibrous capsules. Bacteriological examination by smear, by culture, and by inoculation, was entirely negative. In Cornil's first case, a nodule, of the size of a hazel-nut appeared in the masseter muscle; microscopically, it was a conglomerate tubercle, showing typical structure, with commencing caseation. His other case was of more usual type—cold abscess in the muscles of the thigh, unconnected with any disease of bone. R.

The Bacteriology of Cerebro-Spinal Meningitis.—In view of the very varied descriptions of the meningococcus which still find place in the text-books, it is important that the careful observations of recent investigators should be on record. We, therefore, call attention to a paper by Symmers and Wilson on the cultivation of the meningococcus in the Belfast epidemic (*British Medical Journal*, June 22, 1907). They examined 75 cases, either *postmortem*, or by lumbar puncture during life. In 52 of these, the meningococcus was separated from the spinal fluid. They examined the blood of 15 patients during life, and found the organism in 3 cases. They identify the organism by the following characteristics: (1) The colonies on suitable agar (agar with ascitic fluid and peptone) are smooth, circular discs, grey in colour, translucent, closely resembling colonies of B. coli communis. The colonies are, when first discovered, always discrete. (2) The colonies consist of cocci indistinguishable in size and shape from gonococci. In the older cultures many organisms, spherical in shape, and closely resembling staphylococci, are found. (3) The organism is negative to Gram's stain, although in every culture a few cocci are found which retain the stain with considerable persistence. (4) The organism does not grow at 20° to 22° C. (5) Media containing dextrose and maltose are fermented by the growth, acid being produced, whereas galactose and saccharose remain unchanged. The authors find that the meningococcus grows readily, but during the earlier generations *in vitro* sub-cultures should be made every day. R.

Some New Facts about Agglutination.—Miss Fisher (*Journal of Medical Research*, May, 1907) publishes the results of a careful study of agglutination with special reference to the agglutinins of the various types of dysentery organisms. Some of her conclusions have a general bearing. (1) The use of more than one organism in animal immunisation tends to reduce the agglutinins produced for each of the inoculating organisms. Miss Fisher suggests that this is due either to over-stimulation of the cell due to the action of so many organisms, or to the likelihood that a cell is capable of producing only a certain number of agglutinins. When two or more organisms are used, the number of agglutinins being limited must be divided between these organisms, resulting in a decrease in the agglutination of each. (2) The simultaneous inoculation of various types of organism produces specific agglutinins for each organism, but not in as great quantity as when each organism is injected separately. (3) The agglutination reaction has a very limited value in the differentiation of types of intestinal organism, and has none in distinguishing the various dysentery bacilli. R.

Hæmolytic Properties of Organ and Tumour Extracts.—Weil (*Journal of Medical Research*, May, 1907) attempts to discover the factors giving rise to the anæmia occurring in cases of malignant disease. He first examined the hæmolytic properties of extracts of organs. In this respect he concludes: (1) Extracts of normal organs (liver and kidney) cause hæmolysis of the red cells of the same species of animal, or even of the same animal, but the hæmolytic power varies considerably, or may be altogether absent. (2) If the organ be thoroughly freed from blood, the hæmolytic power is greatly diminished, or altogether lost. (3) Addition of entire blood, or, separately, of leucocytes and serum, to the bloodless organ extracts, diminishes their hæmolytic activity, but addition of red blood cell extract increases the activity of bloodless organ extracts. (4) It is the red blood cell extract *plus* the hæmolytic principle of the organ extract which causes hæmolysis. With regard to tumours, Weil concludes: (1) Tumours differ greatly in their hæmolytic activity, according as they are necrotic or non-necrotic. (2) Non-necrotic tumours are much less auto-hæmolytic than are necrotic tumours. (3) The hæmolytic activity of non-necrotic tumours can be increased by addition of red blood cell extract. (4) The hæmolytic activity of necrotic tumours is not increased by the addition of red blood cell extract. (5) The anæmias of malignant tumours are probably due in part to the hæmolytic and toxic action of the products of necrosis. R.

A Theory of Colour Vision.—Pretorius (*Dublin Journal of Medical Science*, April, 1907) puts forward a theory of colour vision which deserves consideration. He regards the cones of the retina as made up of a series of segments, each of which has the property of perceiving its particular colour, the visual sensation being set up by molecular vibration. When all the segments are equally stimulated, white light is perceived. In support of this, Pretorius points out that many of the white rays falling on the lens are dispersed, and that, therefore, the different spectral rays must strike the cone at different segments of its length. We see the light as white, however, in spite of its dispersion, and this synthesis is best explained by his hypothesis. Pretorius adduces many facts which are consistent with his theory but he admits the absence of the possibility of experimental proof. R.

Atypical Leukæmia.—Rychlik (*Zenhalblatt fur Inn. Med.* No. 22, 1907., p. 562) writes on this subject, and describes the case of a youth, æt. 18, who for two months had suffered from a splenic tumour, and who, during nine months was jaundiced, and had pain in the region of the gall bladder, though with normally coloured stools. Hæmic cardiac murmurs were present, but there was no glandular enlargement and no pain over the long bones. The blood examination gave 3,624,000 red corpuscles; 15,600 white cells; and 50 per cent. hæmoglobin. The plasma was coloured yellow with bilirubin, and some normoblasts and myelocytes were detected. The diagnosis made was that of Banti's disease in the second stage, and a splenectomy was performed. Six hours after operation the red cells numbered 6,050,000 per ccm.; the leucocytes 31,280 per ccm.; and the hæmoglobin was 65 per cent. Twenty-four hours after the operation the numbers were:—Red cells 6,104,000; white cells 25,600; hæmoglobin 65 per cent. The patient died shortly afterwards, and the autopsy showed general hypertrophy of the mesenteric glands, and of the intestinal lymphatic tissues; a lymphoid state of the bone-marrow; partial myeloid alteration of the spleen, and islets of myeloid cells in the kidneys. The writer criticises the latest views of Banti's disease, and identifies the condition with Maixners' hæmorrhagic cirrhosis of the liver. He regards the leukæmias as quite distinct from infectious granulomata, and more inthe nature of specific re-actions to definite irritants. M.

Contraction of the Stomach in Polyserositis.—Scery (*Archiv. fur Verdaungskrankh*, Bd. xivi. heft 1), as the result of a microscopical and macroscopical examination of a case of the above, comes to the following conclusions:—Simple inflammatory contraction of the stomach is a disease *sui generis*. The cause in most observed cases has been chronic hyperæmia in diseases of the heart. It consists essentially of a chronic inflammatory hypertrophy of the connective tissue in the serous and submucous coats. In the sclerosed tissue the blood vessels and lymphatics become narrowed, and further one often finds a chronic inflammation of the gastric glands, with increase of the connective tissue between them. A similar fibrous hyperplasia may occur in cases of chronic inflammation, such as is set up by alcohol or syphilis. M.

Diabetic Lipæmia.—Klemperer and Umber (*Zeitschr. f. Klin. Med.*, Bd. 61, L. 145) state that lipæmia is not characteristic of severe diabetes or of diabetic coma alone, but is to be found in about one half of all cases. It depends in part upon a real increase of the cholesterin and lecithin, and only in some cases to an actual increase in the fat of the blood. In two cases examined, for example, the amount of fat present was from .4 to .6 per cent., which is hardly up to the normal; whilst the cholesterin percentage was 3 to 4 times normal, and in one case more than 10 times normal. Owing to the fact that the subcutaneous and mesenteric fat is not rich in cholesterin, this condition cannot be explained as being due to a simple fat transport from one part to another. The authors think that it must be due to the excessive destruction of fatty substances in nerve tissue, or to the breaking down of proteid-containing tissues. M.

The Influence of Coloured Lights upon Blood-pressure.—Spiston has carried out a series of experiments on the above subject. They were made for the most part upon young men of from 23 to 25 years of age and the exposures took place either after the individual had been for some time in diffuse daylight or in complete darkness. The following were the more important results:—(1) The blood pressure sinks progressively under the influence of red and green light. This fall takes place rapidly, and soon reaches a minimum at which it remains almost stationary. (2) The blood pressure under the influence of blue light at first rises, but only slightly, and then falls, but not to so low a level as with green or red light. (3) On returning to daylight after exposure to coloured lights, the blood pressure rises and reaches the normal level in about ten minutes. (4) On going into the dark after exposure to daylight the pressure sinks slightly, but not to so low a level as with any of the coloured lights mentioned above. (5) Red and green light following blue light produces a fall in pressure, while blue light after red or green causes a rise in blood pressure. M.

King Edward's Hospital Fund.

Amongst the latest contributions received at the Bank of England for King Edward's Hospital Fund for London are the following:—Annual subscriptions: Messrs. Coutts and Co., £250; Messrs. Glyn, Mills, Currie, and Co., £250; Mr. Cecil H. Oliverson, £250; the Duke of Westminster, £100; Sir H. Seymour King, M.P., £50. Annual subscription to additional permanent income fund: Viscount Iveagh, K.P., £500.

North-East London Clinical Society.

The annual meeting of this popular society was held on July 4th, the President, Dr. Arthur E. Giles, being in the Chair. The following officers were elected for the year 1907-8:—President, Dr. M. C. Corner. Hon. Treasurer, Mr. Herbert W. Carson. Hon. Librarian, Dr. A. J. Whiting. Hon. Secretaries, Drs. G. P. Chappel and G. R. Plaister. After the report of the Council and the balance-sheet for the past session had been adopted, the meeting resolved itself into a social gathering, which was well attended by the members, including ladies.

The new City of London Lying-in Hospital, City Road, was opened on July 1st by Princess Christian. Her Royal Highness was received by the consulting physician (Dr. C. Godson), the consulting surgeon (Mr. J. Langton), and other members of the reception committee, by whom she was escorted over part of the new buildings.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

A. M. S.—The quotation you ask for comes from the preface of Stevenson's poems. It runs as follows:—"There are men, and classes of men, who stand above the common herd; the soldier, the sailor, and the shepherd not unfrequently; the artist rarely, rarer still the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilisation, and when that stage of man is done with, and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as it is possible to those who practise an art, never to those who drive a trade; discretion tested by a hundred secrets; tact tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage. So it is that he brings air and cheer into the sickroom, and often enough, though not so often as he wishes, brings healing."

Mr. Thorne Baker's paper is unavoidably held over until our next.

ACCIDENT INSURANCE TO MEDICAL MEN.

A corresponent asks if subscribers to this journal are insured against accident and death. Our reply is that it is not necessary for a journal of the standing of The Medical Press and Circular to attract subscribers by these methods, as every medical man who uses an ordinary sixpenny or shilling diary, is insured against accident and death without cost to himself if he will only take the trouble to read and carry out the instructions of the coupon which is to be found in almost every diary published. Thus, if the coupon be filled in, and the possessor be killed in a railway acident, his representatives can claim £1,000. If killed by tramway, omnibus, or cab accident, £500, while, in the case of non-fatal accidents, smaller sums are paid, according to injuries, and weekly allowances in other cases.

Compensation.—Our correspondent can insure his coachman, as well as his horse and carriage, in "The Imperial Accident and Live Stock Insurance Company," 17, Pall Mall, London.

O. F. H. (Glasgow).—The new work on anatomy by Prof. A. M. Buchanan would best answer your purpose, as it embraces both systematic and practical teaching, and is particularly well illustrated.

C_2H_5OH.—The question is really one for a lawyer, but we may refer you to the Habitual Drunkards Act, 1879, which allows a separation to be applied for by a woman whose husband is an habitual drunkard. In case of a husband, a separation could be obtained by the Licensing Act, 1902, which included drunkenness as one of the causes for separation under the Summary Jurisdiction (Married Women's) Act, 1895.

Meetings of the Societies, Lectures, &c.

Wednesday, July 10th.

Dermatological Society of London (11, Chandos Street, Cavendish Square, W.).—5.15 p.m.: Meeting.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. H. L. Barnard: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. W. Langdon Brown: Sudden Death.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

Thursday, July 11th.

British Gynæcological Society (20, Hanover Square, W.).—8 p.m.: Exhibition of Specimens.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.)—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

Hospital for Sick Children (Great Ormond Street, W.C.)—4 p.m.: Lecture:—Dr. Thursfield: The Diagnosis, Prognosis, and Treatment of Pleural Effusions in Children.

Saturday, July 13th.

Incorporated Society of Medical Officers of Health (Town Hall, Colchester).—11.15 a.m.: Paper:—Dr. W. G. Savage (President of the Eastern Counties Branch): Recent Work upon the Bacteriology of Typhoid Fever in its Relationship to Preventive Measures.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. W. Dodd: Clinique. (Eye.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

Ayr District Asylum.—Junior Assistant Physician. Salary, £120 per annum, with board, apartments and laundry. Applications to the Medical Superintendent.

West Suffolk General Hospital, Bury St. Edmunds.—House Surgeon. Salary, £100 per annum, with board and lodging. Applications to the Secretary.

Egypt.—Sub-Inspector of Ophthalmic Hospitals. Salary, £500 per annum, with two months' salary in lieu of travelling expenses to and from England. Applications to A. F. MacCallan, Esq., 32 Bedford Gardens, Kensington, W.

Stockton and Thornaby Hospital, Stockton-on-Tees.—House Surgeon. Salary, £180 per annum, with residence, board and washing. Applications to H. G. Sanderson, Secretary, Exchange Offices, Stockton-on-Tees.

Monmouthshire Asylum, Abergavenny.—Senior Assistant Medical Officer. Salary, £250 per annum, with board, furnished apartments, washing and attendance. Applications to the Medical Superintendent.

Middlesex Hospital, W. (Cancer Department).—Medical Officer and Registrar. Salary, £100 per annum, with board and residence. Applications to F. Clare Melhado, Secretary-Superintendent.

Rotherham Hospital and Dispensary.—Senior House Surgeon. Salary £100 per annum, with rooms, commons, and washing. Applications to the Secretary, H. Kelson, Masonic Buildings, High Street, Rotherham.

Appointments.

David, John, M.B., C.M.Glasg., a District Medical Officer by the Neath (Glamorganshire) Board of Guardians

Ewing, J. Millar G., L.R.C.P. and S.Edin., House Surgeon to the Wallasey Dispensary and Victoria Central Hospital, Liscard.

Gunning, Charles John Hope, M.R.C.S., L.R.C.P.Lond., Anæsthetist to the Victoria Hospital for Children, Tite Street, Chelsea, S.W.

Logan, Frederick Thomas Bishop, L.R.C.P., L.M.Edin., M.R.C.S., Medical Officer for the Bishopsworth District of the Long Ashton (Somerset) Union.

Macphail, Alexander, M.B., M.S.Glasg., Lecturer on Anatomy at the Charing Cross Hospital Medical School.

Robbs, C. H. D., M.B.Lond., Certifying Surgeon under the Factory and Workshop Act for the Grantham District of the County of Lincoln

Rynne, M. A., M.D.Dub., Certifying Surgeon under the Factory and Workshop Act for the Cheltenham District of the County of Gloucester.

Symes, J. Odery, M.D.Lond., Physician to the Bristol General Hospital.

Chiles-Evans, David Brynmor, L.R.C.P.Lond., M.R.C.S., Assistant Medical Officer at the Swansea Workhouse.

Colyer, Stanley, M.B., B.S.Lond., D.P.H., House Physician at the General Lying-in Hospital, York Road, Lambeth.

Coombs, Carey, M.D.Lond., Assistant Physician to the Bristol General Hospital.

Births.

Dodgson.—On July 2nd, at Sherburn House, Durham, the wife of G. S. Dodgson, M.B., of a daughter.

Hayes.—On June 27, at Dunvegan, Longton Grove, Sydenham, the wife of J. Hayes, L.R.C.P.I., of a daughter.

Owen-Taylor.—On July 6th, at Cherwell House, Nottingham, the wife of Herbert Owen-Taylor, M.D., of a daughter.

Marriages.

Dickins—Taunton.—On June 26th, at St. Nicholas, Worcester, Sidney John Oldacres Dickins, M.D., of Cowfold, Sussex, to Cicely Margaret, elder daughter of W. W. Taunton, B.Sc., M.R.C.P., of Worcester.

Giles—Cooper.—On July 4th, at St. James's Church, Kidbrook, Blackheath, Hubert Mathieson, elder son of Captain H. Giles, R.N., of Little Heath, Alverstoke, Hants, to Florence Muriel, only daughter of Peter Cooper, L.R.C.P.Lond., M.R.C.S.Eng., of Stainton Lodge, Blackheath.

Kenyon—Kilroy.—On July 3rd, at All Saints' Church, Ryde, Leslie Kenyon, to Daisy, youngest daughter of the late Philip Le Feuvre Kilroy, Lieut.-Colonel., R.A.M.C., and Mrs. Kilroy, Fairfield, Ryde.

Stockdale—Bultin.—On June 29th, at St James' Church, Dundee, Natal, Frederick Risley, ninth son of the late Charles Carrington Stockdale, of Highbury, of H.M. Civil Service, to Gertrude Eveline, elder daughter of Charles Henry Butlin, M.R.C.S., of Plymouth, late of Camborne, Cornwall.

Webster—Murphy.—On July 3rd, at St. Mary Shandon Church, Cork, the Rev. James Henry Webster, fifth son of George Webster, of Bandon, to Harriet Dora, only daughter of the late Major F. H. S. Murphy, M.D., R.A.M.C., and of Mrs. Murphy, Cork.

Deaths.

Davey.—On July 5th, at Havering House, Abergavenny, Norris Fasham Davey, M.R.C.S., L.R.C.P., late of Romford, Essex, in his 88th year.

Forshall.—On July 6th, at 12, Southwood Lane, Highgate, Francis Hyde Forshall, M.R.C.S., aged 74.

Kelly.—On June 29, at 13, Mellifont Avenue, Kingstown, co. Dublin, suddenly, from heart failure, Lieut.-Colonel James Bennett Kelly, R.A.M.C., Retired.

Lloyd Owen.—On July 4th, at Kent Lodge, Southsea, Alfred Lloyd Owen, M.D., aged sixtyone years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, JULY 17, 1907. No. 3

NOTES AND COMMENTS.

Surgeon and Butcher.

Notes and Queries has lost none of its interest even though the hand of its founder and editor has alas! been removed. A correspondence has been learnedly and briskly raging in its columns of late as to whether the alleged custom of not putting surgeons and butchers on juries to try murder cases ever had a *de facto* existence, and, if so, what was its origin. It seems doubtful whether a regular custom actually existed, but there seems to have been some feeling on the subject, the alleged reason being that surgeons and butchers were so much habituated to cruelty that they would not be good judges of the moral enormity of murder. Surgeons to whom the information comes as news will, we hope, be duly appreciative of their association with butchers in this connection, and still more so of their supposed brutality. In the innocence of our hearts we have hitherto believed that the medical men are excused jury service in recognition of their arduous toil for the benefit of our common humanity, and because of the amount of unremunerative labour they devote to the State in the exercise of their profession. But in future we must not lay this flattering unction to our souls, for it seems that the real cause for exemption from jury service is to be found in the moral depravity which was supposed to be an indissoluble accompaniment of the surgeon's art. That some such feeling did actually exist seems beyond doubt, and the pre-anæsthetic operative surgeon must necessarily have been a man who could subordinate his natural feelings of mercy to the prosaic and sanguinary requirements of the moment, but if only for the sake of his own practice it is hardly likely that the surgeon of old days would have cultivated deliberate callousness.

"Dressed like a Medical Student."

HOWEVER, the pursuit of natural knowledge used generally to be credited with a tendency to make men irreligious, and that of medicine with making them both brutal and unmannerly. The great Dr. Arnold, of Rugby, who in his generation was accounted one of the most ardent reformers, and who possessed a more open mind than most of his contemporaries, strongly opposed the admission of medical students to Oxford because of the strong tendency of their presence and manners to debase undergraduates reading divinity and polite letters—an objection which was vigorously supported on all sides. It savours perhaps of unctuous rectitude to say, with the snail, that we have changed all that, but even if it is the fact, as we ourselves unhesitatingly believe, the old tradition dies hard. Any audacious lark or low street trick is the work of the medical student still in the eyes of mentors of the press. A more than usually amusing instance of this gratuitous assumption occurred in connection with the "Strand Baby" case last week. As most readers know, a young man and woman entered the West Strand Post Office one evening with a baby, and after some preliminaries despatched the infant to a lying-in hospital by messenger boy, and then decamped. As the incident furnished good copy, there was a tremendous clatter in the yellower organs of the press, and many puerile theories and clues were put forward to keep the public agog. One reporter had an "interview" with one of the Post Office clerks, on the strength of which he obtained details of the costume of the couple. The man wore a tweed suit and a large baggy cap such as is the fashion of the moment, being, in fact, said the account, dressed like a medical student. A medical student, then, on this conclusive evidence, must have done the dark deed. We did not know that there was anything particularly distinctive about the dress of medical students, and whatever there may have been in this particular instance was rendered nugatory by the event, for, when the man was found two or three days later, it turned out that he was a postman.

One Inspector, One Microbe.

THE recent proceedings of the new London County Council with regard to the milk-supply of the metropolis pass the wit of man to understand. In the first place, on taking office the Council withdrew from their Bill then before Parliament all the clauses giving them greater powers of inspection and supervision of the milk-trade; then a few months afterwards, recognising that this move was a mistake, they proceeded to refer the matter to the Public Health Committee with a view to obtaining such powers from Parliament. Last week, when the report of this Committee came up for discussion, they passed an amendment which amounted practically to a decision to do nothing beyond making representations to the Local Government Board about the unsatisfactory state of the milk-trade. By way of illustrating the practical knowledge possessed by the Council in the matter, one member got up and moved an amendment demanding that no milk should be sold in London except in glass-bottles, hermetically sealed, and having on them the name of the farmer and the stamp of an authorised inspector guaranteeing the purity of the contents. He pointed out that to be certain of the freedom of milk from contamination under any proposal, an army of inspectors would have to be employed all along the line, but according to his proposal the inspectors would only be needed at the source. We shudder to think what the price of milk would mount up to under such a system, and also at what hour in the day it would reach the consumer. A speaker who followed made play with this visionary proposal, and said that its chief virtue consisted in the amount of work it would provide for the unemployed. Indeed, it seemed to him to be a case of one inspector, one microbe. The amendment was lost on a division, it is true, but the ugly fact remains that the Council exhibit every symptom of being possessed with a desire to burke the main question, and there seems no way of getting them up to scratch and keeping them there.

The Doctor as Parson.

The Reverend H. Tracey, of St. Saviour's, Dartmouth, is, we gather from a recent article from his pen, one of those enlightened members of the clerical profession who see that the Church has a social, as well as a spiritual duty to the State, and that in its performance important help will be readily forthcoming from medical men. Mr. Tracey, it seems, has long liked to have doctors read the lessons in his church, but this passive use of their energies he would now like to see supplemented by the more active one of preaching. The late Dean Stanley frequently invited distinguished laymen to preach from the lectern in the Abbey, and Mr. Tracey advocates the extension of this principle to medical men. "To have expert testimony to the value of cleanliness, purity, sobriety, simplicity of living, the ease of extracting the greatest nutriment from the simplest and cheapest food, the beneficent effect of sunlight, fresh air, pure water, regular work, regular play, and similar topics would" he writes, "be of infinite value, and would 'save' the bodies of many who would then see how rational it was to 'save' their souls as well." There is, we believe, no reason why medical men should not be licensed to preach in churches, but we do not know of any instance in which any one of them is. That the advocacy of such principles as Mr. Tracey suggests would do more for people's lives than many of the platitudinous utterances that pass for sermons would hardly be denied by anyone conversant with the facts.

Death of Sir William Broadbent.

The death of Sir William Broadbent removes from the medical world a big figure, for although to the public Sir William was known chiefly as a Court physician, by his colleagues he was respected as a particularly sound and accomplished physician. He had formed his views not on intuitions and ideas, but on the broad basis of accurate clinical study, and they were therefore not only firmly held, but well-grounded in commonsense. He knew his own mind and spoke it with Yorkshire-like directness, but he was generally right and invariably high-minded. His promotion to Court circles at the time of the Prince of Wales's illness was something of a surprise when it occurred, as he had not trodden in the Jennerian footsteps, but not only did his skill soon recommend him to the friends of his Royal patient, but, we believe, the King and Queen entertained a very high regard for him both personally and professionally. Sir William Broadbent had many of the qualities that make a leader of men, and he would have been sure of success in almost any line of life, but it is as a leader of good causes in the profession that he will be most immediately and truly missed.

LEADING ARTICLES.

THE GENERAL MEDICAL COUNCIL AND THE DENTAL COMPANIES' BILL.

The General Medical Council is the only body to which we can turn hopefully as the active instigator and framer of legislation calculated to protect professional interests. Undoubtedly the great want of medical practitioners at the present moment is an Act that will put an effectual stop to the unlawful practice of medicine for gain and the sale of quack medicines. By satisfying that demand Government would also be taking a step of unmeasurable importance towards the better safeguard of the welfare of the public.

The legislature that draws up stringent medical Acts providing for the efficient education and legal qualification of medical practitioners recognises the absolute need of careful special training for the practice of medicine. If the same legislature permit quacks and charlatans to perform medical functions, then it nullifies its former position, assumes the right of any man to practice medicine at his own free will, and practically says that the public does not require to be protected against irregular practices. The State, in other words, declares that a thing can both be and not be: that the man in the street requires to be protected against ignorant medical men, but not against ignorant quacks. Yet the Government of this country is not without some saving grace, so far as the attempt to keep in touch with medical aims, ideals and aspirations is concerned. The General Medical Council occupies an advisory position of great weight by virtue of its connection with the Privy Council. The opinion of the great so-called governing body of the profession is sought upon medical questions that may come under the consideration of the legislature. It is always of interest, therefore, to ascertain as far as possible, in what directions that influence has been brought to bear. The interests of the dental profession are in charge of the General Medical Council. They are professedly involved in the Bill now before Parliament to restrict the practice of dentistry by private or public companies.

The General Medical Council has promoted the Bill known as the Dental Companies' (Restriction of Practice) Bill. The opinion of the dental profession with regard to the Council's championship of their rights may be gathered from a leading article in the *British Dental Journal* for July 1st, 1907. "We wish to speak in terms of moderation," it says, "but desire at the same time to rouse the dentists of the country to a sense of the injustice and injury which that Bill will inflict upon them and the people should it unfortunately pass. . . . The Bill is careful enough to provide for something which never has occurred and never is likely to occur, viz., the formation of a company to carry on dental practice by means of qualified men ; and careless enough to legalise by a few ill-considered words the practice of dentistry in one of its most important branches by unregistered men. There can be no doubt that if this clause stands, hundreds of qualified dentists who have spent much time, money, and exertion in obtaining a registrable diploma will be ruined." These strong words, coming from a responsible and authoritative source, can hardly fail to engage the earnest consideration of the General Medical Council. If it be the serious intention of the Government to defend the interests alike of the qualified dentists and of the public by fresh legislation, then it is evident the present Bill will have to be recast. But the attitude of the General Medical Council has an important bearing upon the interests of medical practitioners who find themselves hampered by competition with companies formed to carry on all sorts of medical treatment, and to sell all kinds of nostrums claiming to cure all sorts of ailments. Will the General Medical Council be able to frame a better Bill for the protection of medical men than it has for dental surgeons ? Precisely identical principles are involved in both cases, and just the same zealous sympathy, informed wisdom and resolute determination are demanded in the one instance as in the other. The present position appears to emphasise the inherent weakness of the Council in its virtually non-representative constitution. In conclusion the following passage from the *British Dental Journal* may be quoted :—" We are by this Bill most shamefully entreated. We have for long been used to being ignored, flouted and misunderstood by the Medical Council, and in spite of it all we have displayed to that body a passionate loyalty that in the light of this Bill is truly pathetic. The memorandum states that the Bill has the support of the General Medical Council ! We are indeed wounded in the house of our friends."

CURRENT TOPICS.

For London or for the United Kingdom ?

WHEN the Royal Society of Medicine was constituted we looked forward with special pleasure to its probable effect upon the Obstetrical and Gynæcological Societies. We expected that nothing but good could come from such a union, that the Obstetrical Society would gain very materially by the broadening of its views consequent on the influx of new members, and that the Gynæcological Society would also profit by acquiring an equal share in the prestige of the older Society. No one could doubt that both consequences were very much to be desired. The Obstetrical Society had always something in its atmosphere which seemed to stifle those who would have levelled up London obstetrics and gynæcology. The Gynæcological Society lacked the prestige of age and associations which one naturally looks for in the case of an important institution. It is therefore with very keen regret, and we confess with not very hopeful forebodings, that we have read the list of " officers recommended by the Council " for election at a Special General Meeting to be held in October. It is at once apparent from this list that so far from this particular section of the Royal Society of Medicine being one which will seek to attract to its ranks prominent obstetricians and gynæcologists from all parts of the United Kingdom, it is to be again a mere repetition of the Obstetrical Society. For the new Council there have been nominated, by the existing Council, twenty-nine members from London, six members from the English provinces, one member from Scotland, and not even a single Irish representative. Now, Scotland is very well able to look after its own interests, and therefore we shall not comment on the curious manner in which its specialists have been welcomed to the ranks of the new section. We turn now to the case of Ireland. We believe we are correct in saying that in the list of past and present officers of the British Gynæcological Society there are the names of at least two Irish ex-presidents, and at least three Irish ex-vice-presidents, not to speak of others who have been members of the Council. We believe we are also correct in stating that these gentlemen were invited to join, and did join, the new section, together with other Dublin obstetricians and gynæcologists who were members of the Gynæcological Society. Yet of them not a single one has been considered by the existing Council to be worthy of a place on the new Council. When policy, civility, and ordinary fairness unite to point out a certain course of action there must be a very definite reason why the course is not followed. What that reason is time will show. We trust it is not due to a desire to maintain the traditions of the Obstetrical Society.

Instruction for Mothers.

WE are glad to learn that some recent ventures in the Metropolis directed toward the instruction of mothers are progressing satisfactorily. For some years, in Paris, Brussels, Ghent, and other continental cities, centres have been established where mothers could obtain proper advice as to the care and feeding of young children. More recently the Marylebone Health Society and the St. Pancras Mothers' and Infants' Society entered on similar work in their respective districts of London. Mothers and expectant mothers are taught how to wash, clothe, feed, and generally tend young infants, and the importance of natural feeding is emphasised. In cases where artificial feeding is necessary, the mother is given instructions on the preparation of the most suitable foods. It is claimed that the result in the shape of healthy, well-nourished children is most gratifying, and we can well believe it. It is a commonplace that the greater part of infant mortality is due to ignorance rather than carelessness or crime, and any effort to dissipate this ignorance deserves the hearty support, not only of the medical profession, but of all interested in the welfare of the race.

The Adequacy of Fines.

THE necessity of enforcing high standards of purity in food and drugs has been recognised in many Acts. There are many ways, however, in which the intention of the legislature may be frustrated. In some cases the machinery of the local authorities for the collection and testing of samples is defective. In others the limit of the penalty that may be imposed is too small to be of any real deterrent effect upon offenders, or magistrates may be too lenient in the matter of fines. It is notorious that certain fraudulent milk-sellers find it a paying business to go on selling adulterated milk and to charge against profits the fines that are constantly imposed upon them. In the matter of meat and tinned goods magistrates, as a rule, are inclined to impose full penalties. Last week a penalty of £50 and £2 2s. costs was imposed upon the keeper of some stores in Camberwell for exposing for sale tinned and bottled goods unfit for human consumption. Were all fines for this class of offence fixed on a similar scale of adequacy, the safety of the public would be proportionately increased. In a matter of this kind, above all others, it is desirable to have some sort of concerted action amongst the magistracy in their administration of the law.

A Year's Trade Accidents.

THE Annual Report of the Chief Inspector of Factories and Workshops for the year 1906 was issued, on the 10th inst., in the form of a Parliamentary paper. The document registers a great advance in the condition of industrial labour. At the end of the year there were 109,065 factories and 146,124 workshops upon the registers. The number of persons employed in factories is about 4,150,000, in workshops 700,000, and in laundries 100,000. The total number of accidents reported in the year 1906 reached the great number of 111,904, of which 1,116 proved fatal. These figures show an increase of 11,295 accidents, or 11·2 per cent. as against the preceding year; while the fatalities are greater by 53 or 5 per cent. It is interesting to note that the greatest number of fatal accidents, namely, 149, occurred in the making of machines, engines, &c., while 145 occurred in the construction of buildings, and 143 in docks. The cases of industrial poisoning totalled 707, of which 54 ended fatally. Only one case of phosphorus poisoning was reported. Attention is called to the coming into force of the Workmen's Compensation Act, 1906, which it is pointed out, broadens the scope of the earlier Acts, and in particular extends compensation to certain scheduled industrial diseases. In view of the importance of the new Act, the attention of medical practitioners may be drawn to this important Parliamentary paper.

Medical Practice by Companies.

PARLIAMENTARY proceedings with regard to medical practice by companies are of vital importance to the medical profession. Some weighty evidence has been laid before the Lords by the chairman of the London and Counties Protection Society and the Secretary of the Medical Defence Union. Dr. G. Heron pointed out forcibly that the limitation of the scope of the proposed Bill to joint stock companies would render it almost valueless, as the majority of such companies were of a non-joint stock nature. Dr. A. G. Bateman went to the root of the matter when asked whether he had any suggestion or amendments in connection with the Bill. "I am afraid," he replied, "that the only amendment we should like would be a complete alteration of title and a complete alteration of the clauses, so as to put a stop to medical practice for gain by persons who are not qualified." That is the bed-rock of the question. The legislature is asked to stop medical practice by companies who collectively perform acts that individually performed would be illegal. If the safety of the public demands that unqualified practice of medicine by companies be abolished, why not also that of individuals? The view so clearly and courageously advanced by Dr. Bateman would come naturally and gracefully from the General Medical Council.

Ingenious Milkmen.

A CERTAIN class of milk vendors exercise a fiendish ingenuity in devising methods for adding to their legitimate income a profit obtained by fraud. It is, of course, highly important (to the offender) that the method adopted should not bring him within reach of the law, and hence, while he courteously supplies the stranger with a genuine article, his long-suffering regular customers do not obtain milk "of the nature, substance, and quality demanded." The procedure of some sinners within the Borough of Portsmouth in the sophistication of their milk is mentioned by the Public Analyst, Mr. F. W. Arnaud, in his annual report. The milk vendor carries two churns on his cart, one containing skim, and the other whole milk. The former churn is duly labelled "separated milk," but the label is stuck so near the base of the churn as to pass unobserved by anyone not standing immediately over the cart. Customers are served from a small can, which never contains much more than is required by the next customer. For regular customers a special mixture from the two churns is supplied, while a suspicious-looking stranger is supplied from the churn containing genuine milk. If necessary, the milkman obligingly points out the label "separated milk" to the inspector. When it is remembered that an average genuine milk can be diluted with 30 per cent. of separated milk without bringing the fat below the 3 per cent. standard, it will be seen that the vendor will not be liable to prosecution if the small can contains a little of the "regular customer's mixture," when the genuine article is run in for the inspector. Mr. Arnaud suggests the necessity for a new Act rendering it illegal to carry both whole and separated milks on the same cart. Meanwhile, the inspector is baffled, and the offender grows rich at the expense of the consumer.

PERSONAL.

On July 13th, Degree Day at Liverpool University, the following honorary degrees were conferred :—Professor F. Gotch, D.Sc.; Professor W. Osler, D.Sc.

The Court of Governors at Guy's Hospital sanctioned the formation of an orthopædic department, and appointed Mr. R. P. Rowlands, M.S., as surgeon to the hospital in charge.

Lady Broadbent on July 11th received the following telegram from Sir Arthur Bigge :—"The Prince and Princess of Wales are grieved to hear of the irreparable loss which you have sustained, and desire me to assure you and your family of their true sympathy in your sorrow."

Lieutenant-Colonel Sir J. Fayrer, medical officer of the Duke of York's School, has been appointed to the medical charge of the Union Jack Club.

Sir Alfred Jones, K.C.M.G., the president of the Liverpool School of Tropical Medicine, has received a grateful letter of thanks from the President of the Republic of Peru, acknowledging copies of a report in Spanish on the "Health of Iquitos," by Dr. H. Wolferstan Thomas, member of the yellow fever expedition of the school.

On July 11th the members of the Birmingham Medical Benevolent Society presented an address and a handsome service of silver plate to Mr. W. F. Haslam, who recently retired from the post of honorary secretary to the society, after sixteen years' service.

Dr. J. Ll. Williams, of Wrexham, has been appointed medical referee under the Workmen's Compensation Act, 1906, for the County Court districts of Corwen and Bala and Wrexham and Llangollen.

Dr. Robert Barnes, whose death, at the age of 89, was recently referred to in these columns, has left estate valued at £183,074 gross, with net personality £175,176. He left £500 each to St. George's Hospital and St. George's Hospital School, London; the Medical Benevolent College, the Dreadnought Seamen's Hospital, and St. Thomas's Hospital; £300 to the Royal Maternity Charity; and £200 each to the School of the London Hospital and the Princess Alice Memorial Hospital, Eastbourne.

Dr. G. G. Shattock has been appointed to deliver one Erasmus Wilson lecture on Ovarian Teratoma, and Dr. J. W. H. Eyre, M.S., Dub., and Mr. Leonard S. Dudgeon, lectures on other subjects.

Mr. James Taylor, F.R.C.S., has been made the recipient of a handsome testimonial on his retirement after forty years' service on the surgical staff of the Chester Infirmary.

Dr. George W. Crowe, of Worcester, was entertained at dinner and presented with a piece of plate by his fellow-members of the Worcestershire and Herefordshire Branch of the British Medical Association at the end of last month.

Lady Duckworth-King is to open the recently-erected electrical department of the Royal Devon and Exeter Hospital, presented by Mrs. Sanders, on Friday next.

Mr. Hudson E. Kearley, M.P., will distribute the prizes to the students and nurses of the London Hospital this afternoon at 3.30 in the library of the Medical College.

The prize distribution at St. Mary's Hospital, which was to have taken place on July 11th, has been indefinitely postponed in consequence of the death of Sir William Broadbent.

Dr. C. E. Underhill presided over a luncheon on July 6th given by the Royal College of Physicians of Edinburgh to the medical officers of the Channel Fleet.

Dr. W. F. Surveyor has been appointed to the chair, of bacteriology at the Grant Medical College, Bombay.

The Duke and Duchess Karl Theodor of Bavaria have just arrived in this country. For many years the Duke has performed operations for cataract, the total of which has already exceeded 5,000. He is assisted in his work by the Duchess.

The Science Committee of the British Medical Association has adjudicated the Middlemore Prize to Mr. Sydney Stephenson, for the outstanding merit of his essay upon Ophthalmia Neonatorum. This prize is awarded every three years for an ophthalmic subject.

Mr. Henry Morris has been re-elected President of the Royal College of Surgeons of England.

Mr. Watson Cheyne, C.B., F.R.S., and Mr. Rickman Godlee, F.R.C.S., have been elected vice-presidents of the College of Surgeons of England for the ensuing collegiate year.

Mr. W. S. Handley, M.S.London, has been appointed Hunterian lecturer for one lecture on the Therapeutic Criteria of Cancer, and Dr. V. Bonney, M.S.London., for three lectures on the Connective Tissues in Carcinoma. Mr. B. Armour, M.B.Toronto, Mr. A. R. Thompson, M.B.Vict., and Dr. F. C. Shrubsall, are to give other lectures.

Dr. F. A. Bainbridge, M.A.Camb., has been appointed Arris and Gale Lecturer, to give one lecture on the Pathology of Acid Intoxication, and Mr. Major Greenwood, junr., two lectures on the Physiological and Pathological Effects which follow Exposure to Compressed Air.

A portrait of Dr. John Beddoe, F.R.S., has been formally presented to the City of Bristol by the Right Hon. Lewis Fry.

In our "Births, Marriages and Deaths" column today are two announcements which read side by side appear almost tragic. On the 9th inst., the son of Mr. Samuel Benham, M.R.C.S., of Hampstead was married; the next day the sudden death of the father occurred.

A Clinical Lecture

ON

THE TREATMENT OF CARCINOMA OF THE GREAT INTESTINE. (a)

By SETON PRINGLE, M.B., B.Ch. (Univ. Dub.), F.R.C.S.I.,
Surgeon to Mercer's Hospital, Dublin.

Gentlemen.—The subject about what I wish to speak to you this morning is the treatment of carcinoma of the great intestine exclusive of the rectum. The great intestine, as you know, is a common site for malignant disease, and it is gratifying to be able to state that the treatment of this condition by *early* operation is attended by success in a great number of cases. You note that I lay emphasis on the word *early*, for unfortunately we generally get these cases, at least in hospital practice, only when the disease is far advanced and one or other complication has set in, therefore I want to impress on your minds the importance of making a full and careful examination of every elderly patient coming to you complaining of vague abdominal symptoms such as colicy pain, constipation, diarrhœa, or the passage of mucous, blood or pus in the motions. I believe that at present we do not attach nearly enough importance to the microscopical and chemical examination of the fæces in abdominal cases. You all know how much can be learned from careful examination of the urine, sputum, or gastric contents in diseases of the kidneys, lungs or stomach, and yet in how very few cases of intestinal disease do the fæces receive similar attention? Professor Nothnagel states that in only two conditions are pus, mucus and blood persistently found together in the stools. These two conditions are carcinoma of the great intestine and dysenteric ulceration. The latter disease is usually easily diagnosed, and therefore the discovery of these three abnormal constituents of the fæces would be of the greatest assistance in arriving at the diagnosis of cancer in cases presenting symptoms of intestinal stenosis, but in which no tumour could be felt. Leaving fæcal impaction out of the question, the presence of a palpable tumour in an elderly person with symptoms of complete or partial intestinal obstruction, of course practically settles the diagnosis of cancer, but as in many cases the growth is situated at an inaccessible part of the intestine, such as the splenic flexure, or is too small to be felt, the importance of the knowledge gained by examination of the fæces cannot be over-estimated.

The cases of cancer of the great intestine, which present themselves for treatment, may be divided into two main groups, namely, cases which are not and cases which are suffering from acute intestinal obstruction at the time of examination, and the latter are at least, in my experience, by far the more numerous.

First then as regards the treatment of the cases coming into the former class. As soon as the diagnosis is made, and except the disease is very far advanced and the patient evidently rapidly on the down grade, it is certainly the surgeon's duty to advise immediate laparotomy, and then to be guided in the course he pursues by the conditions found in the abdominal cavity. If the tumour be movable and the lymphatic glands be either apparently normal or enlarged only in the vicinity of the growth, the affected part of the intestine, and at least two inches of normal gut on either side, should be excised. (It is not my intention this morning to describe in detail any of the operations I may advocate, but merely to outline them in a few words). Along with the tumour we must remove either a wedge-shaped piece of the mesentery or, if the intestine at the situation has no mesentery, then as much of the fatty bed on which the bowel rests as can be taken away without endangering the blood supply of the normal gut. In either case our endeavour is to remove in one piece with the growth the lymph channels and glands draining the part. When the growth has been cut away, an end to end anastomosis by suture should be performed in those parts of the intestine which are almost completely surrounded by peritoneum. In other parts, such as the ascending or descending colon the divided ends of the bowel should be closed and a lateral approximation carried out. In the case of the cæcum, where the ileocæcal valve has been removed, it is well to close the lower end of the ascending colon and implant the cut end of the ileum into the lateral aspect of the colon, preferably incising the latter in the line of one of the longtitudinal muscle bands. Frequently we find on exploring the abdomen in these cases that although the patient has not suffered from acute intestinal obstruction, yet a chronic condition of obstruction is present, and here the gut above the stricture will be distended, often enormously so, and the mucous membrane ulcerated, while the intestine below will be contracted. In these cases it is necessary to perform a lateral anastomosis, or sometimes even a temporary colostomy to allow of the distended upper segment of bowel regaining its healthy condition before proceeding to excision of the growth at a later sitting. Of course if another portion of the intestine or the omentum is found adherent to the growth the adherent structure must be removed in one piece with the growth itself. Occasionally in this first class of case we find a growth which is obviously irremovable, and then I consider it is best to perform a lateral anastomosis between the afferent and efferent loops of bowel so as to short circuit the current of intestinal contents, and thus obviate either the occurrence at a later date of acute obstruction or the formation of an artificial anus above the site of the tumour. This operation is comparable to that of gastro-enterostomy for inoperable carcinoma of the stomach involving the pylorus, and even if it is not attended with such obviously beneficial results to the patient, surely it is preferable to the establishment of a permanent colostomy? In this connection I may mention that anastomosis of the transverse to the pelvic colon has been frequently successfully carried out for irremovable growth of the splenic flexure or descending colon.

(a) Being a Lecture delivered at Mercer's Hospital on April 10th, 1907.

The consideration of the treatment of the second group of cases, viz., those in which acute intestinal obstruction is present as a complication of the malignant stricture, is more interesting, as here we have to note the very marked advance of surgical procedure and technique of comparatively late years. Formerly in these cases it was the recognised practice to, if at all possible, excise the growth and perform an immediate end to end anastomosis; but this line of treatment was found to be attended with a mortality of something like fifty per cent. This result is just what might be expected, if you consider the condition of the intestine in an acute obstruction. The gut above the stricture is enormously distended with decomposing fæcal material and gas, the mucous membrane is ulcerated and the wall in its entire thickness inflamed. How then could we expect to obtain satisfactory union at the line of suture? Is it not evident that the sooner the toxic products of decomposition be allowed to escape the better the patient's chance of recovery? Remember that in the great majority of cases of acute intestinal obstruction the patient is killed by toxæmia and not by any local condition. It is therefore now recognised that the important part of the operative treatment of acute obstruction from growth is the immediate provision of a free outlet for the toxic intestinal contents which relieves the patient's toxæmia and allows the gut to regain its tone and normal structure. It is not justifiable to undertake a prolonged operation with the object of immediate removal of the tumour and restoration of the continuity of the bowel, since the result can be much more safely obtained by carrying out the operative treatment in two or three stages. The number of separate operations is determined by the possibility or impossibility of delivering the growth out of the abdominal cavity. In the first class—*i.e.*, when the growth can be so delivered, the best procedure is to lift the involved loop of intestine out on to the abdominal wall and then, after suturing the parietal peritoneum around the two limbs of the loop, to excise the tumour with a wedge-shaped piece of the mesentery, and tie a large Paul's tube into either cut end of the gut to permit of the free escape of the intestinal contents. If at the same time we stitch together the mesenteric borders of the afferent and efferent limbs of the loop of bowel, then, after some weeks elapse, the spur between the two segments can be safely destroyed by an enterotome, and the artificial anus can be closed, as Paul himself says, "by separating the rosette of mucous membrane from the skin, turning it in and bringing the freshened edges of the latter over it." If the mesenteric borders are not sutured together, then the second and final stage of the operation consists in closing the artificial anus in the usual way.

On the other hand, if we find at the primary operation that the tumour cannot be delivered out of the abdominal cavity, it is best to perform a colostomy above the site of the growth, to relieve the urgent symptoms of obstruction; and then, some weeks later, the abdomen is again opened over the position of the tumour which is excised, and an end to end or lateral anastomosis carried out. In such a case the third or final stage consists in closing the colostomy by a suitable operation. If considered advisable the colostomy can be closed at the same sitting in which the tumour is excised; but personally I consider it is wiser to carry out the treatment in three stages, as we are much more certain of getting satisfactory union at the line of anastomosis if no fæcal material travels over it for a few days.

Within the last few months you have had an opportunity of seeing three cases of carcinoma of the great intestine under my care. All three came into hospital in a condition of acute obstruction.

The first case was that of a man, æt. 65, who some six months previously had been admitted under my care. On that occasion he complained of colicky abdominal pain for the twenty-four hours before admission; he had also vomited several times, and there had been no movement of the bowels; but as he was habitually constipated he attached no importance to the latter fact. His general condition was very good and abdominal distension not a marked feature. I ordered him a large enema, and remained in the hospital to learn the result. The injection brought away a large motion and all his symptoms subsided; therefore, as on careful examination no tumour could be felt in any part of the abdomen, I was inclined at the time to consider his condition as due to fæcal impaction. He was consequently discharged from the hospital in a few days, and remained well except for the troublesome constipation, till he was admitted the second time, six months later, with acute intestinal obstruction. I immediately operated and performed a cæcostomy, but unfortunately he gradually sank and died a fortnight later. At the *post-mortem* a tight malignant stricture at the splenic flexure was found.

The second patient was a woman, æt. 60, who had suffered from constipation for some time, but otherwise had enjoyed very good health till some thirty hours before admission, when acute obstruction suddenly set in. In her case the growth was situated in the lower end of the pelvic colon, and again colostomy was performed immediately, but failed to save her life.

The third case furnishes a good example of the "three stage" operation, and I will therefore enter into more detail in recalling it to your memories. The patient, a labourer, æt. 60, was admitted late one night some months ago, and then gave the following history:—For some years he had been more or less constipated, and for the three weeks preceding admission he had been unable to obtain a satisfactory movement of the bowels, although the very day before coming here he had passed a small motion. After this motion severe colicky pains commenced in the abdomen, and these pains persisted up to the time of admission twenty-four hours later. During the same period he had also vomited frequently. I saw him an hour after his arrival, and found the abdomen greatly distended, while by both palpation and percussion the cæcum and entire length of the colon down to the pelvic brim could be easily demonstrated to be in a very dilated condition. From this it was evident that the obstruction was either situated in the pelvic colon or rectum. I then passed a finger up the rectum and was just able to feel that there was a tumour in the pelvis lying slightly to the left of the middle line. I could not feel the tumour directly, but there seemed to be several thicknesses of gut between the examining finger and the mass. By this time the colicky pains had ceased, no doubt because the intestine was passing into a condition of paralysis or ileus. The diagnosis of cancer of the colon, situated probably about the junction of the pelvic colon and rectum, was easily made, and I had the patient at once prepared for the operation. It is always a wise precaution in these cases to have the stomach washed out preparatory to anæsthesia, as it lessens the risk of the patient developing an inspiration pneumonia should he vomit during the administration. At the operation I opened the abdomen in the left inguinal region by the muscle splitting method, and on passing my hand down into the pelvis I easily found the growth, but was unable to draw it up out of the wound; and consequently I performed a colostomy in the following manner:—I passed as much of the pelvic colon as possible down into the pelvis, so that if I came to attempt excision of the tumour afterwards, the tumour would not be fixed, and thus increase the difficulty of the manipulation. This procedure of selecting as high a part of the bowel as possible for the colostomy also obviates to a great extent the occurrence of prolapse through the artificial opening. I then sutured the parietal peritoneum round an oval area on the free aspect of the selected piece of colon, and finally inserted a large Paul's tube in the centre of the area thus shut off from the general peritoneal cavity. During the next twelve hours some four and a half gallons of fluid fæces escaped through the tube. The patient reacted well, and his general condition improved so much that I decided to, if possible, remove the growth. Consequently, three weeks after the first operation I opened his abdomen in the mid line above the pubis after temporarily sewing over the colostomy to prevent soiling. On passing in my hand I was able to grasp the tumour and draw it up till it was between the lips of the wound in the parietes. I then divided the gut on either side of the tumour between clamps and quickly did an end to end anastomosis by suture; fortunately I was just able to leave enough of the gut below the growth completely covered with peritoneum to allow of this method to be carried out with safety. Again he made a good recovery, and finally some weeks later I successfully closed the colostomy.

These three cases exemplify, at least, one very important point. In all of them we see the insidious manner in which the disease may progress, so very insidious indeed that in two of them the onset of acute obstruction was the first symptom which caused them to consult a medical man. In all, indeed, we find a history of constipation for some time, but this is a very common complaint in old people, and too much stress must not be laid on it. In only one an attack of colicy pain preceded the obstruction by several months, while from none of them could we obtain a history of the alternating attacks of diarrhœa and constipation described as typical of intestinal stenosis. In the third case a gratifying result followed the employment of the "three stage" method of operating, and we may be reasonably certain that had a radical removal of the growth with immediate end to end anastomosis been attempted in the first instance the case would have had a rapidly fatal termination, considering the condition of the bowel at the time of the first operation.

In conclusion, therefore, gentlemen, let me again remind you (1) of the great importance of making a full and painstaking examination of all patients past middle life who complain of any abdominal symptoms at all referable to narrowing of the lumen of the bowel, for only by early diagnosis of these cases can the results of treatment be improved, and (2) of the necessity to provide an immediate means of escape for the toxic intestinal contents in all cases of acute obstruction.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Purves Stewart, M.D., F.R.C.P. Lond., Physician to Westminster Hospital and to the Royal National Orthopædic Hospital. Subject: "Disorders of Sleep."*

ORIGINAL PAPERS.

THE GENERAL PRACTITIONER.

II.—HIS CLAIM TO RECOGNITION.

By J. LIONEL TAYLER, M.R.C.S., L.R.C.P. LOND.

I PARTICULARLY do not wish to claim more than what is obviously the general practitioner's due, but it seems to me there are three aspects that are particularly his own—(1) as an expert in the beginnings of disease; (2) as an expert in common diseases which the consultant and hospital practitioners seldom see; (3) he is the only first-hand observer in the influence of environment on healthy and diseased individuals.

(1) *An Expert in the Beginnings of Disease.*—It is unquestionable that the majority of patients are seen in the first stage of their illnesses by the general practitioner. It may, however, be argued that, in proportion to the much smaller number of specialists, their experience is nearly as large, though I think few would venture to assert this. Were it so, however, it would still be true that the ordinary medical man is in this respect at least as entitled to speak and write authoritatively on this aspect of medicine as the consultant.

As a student, I remember the scarcely-veiled contempt that the young house physician or surgeon and occasionally the senior staff displayed for the general practitioner's skill, and to me the feeling at the time seemed wholly justified. Cases of appendicitis sent in too late; obvious abscesses that were pointing and had been unopened; advanced cases of phthisis undiagnosed; tumours not discovered that were almost visible to the naked eye, and other like conditions passed over apparently ignorantly or carelessly.

When, however, I went into practice myself I learnt otherwise. I was informed by a colleague that text-book and hospital information would help me little. I asked why? He said he did not know, but cases in hospital seemed to be different from those outside. And his conclusion I was soon able to verify.

In fevers, where it is necessary to distinguish the notifiable from the unnotifiable diseases, and the slight cases of febricula from the more defined infections and from the beginnings of tubercular disorders, I discovered that these early symptoms, which are of common every-day occurrence, are scarcely alluded to in our text-books. I accordingly wrote to the superintendent of one of the large fever hospitals, where I had been trained, stating my difficulty, and asked if he could recommend me a work that gave more attention to this subject. In his reply, while regretting that he was unable to suggest any book that would be valuable, but thinking of one the kind needed, he writes that the fever hospital physicians get their cases "a little later than the certifying general practitioner and so have to deal with a more developed disease." It is this conclusion that I had myself reached which is characteristic of the whole aspect of the ordinary medical man's practice. *He sees every disease a little or a great deal earlier than the specialist.*

In no acute disease, if the onset is sudden, does the hospital physician or surgeon see the case before the local one, for the patient either is in bed or goes there as soon as grave symptoms appear. Where the disease is less acute a few cases are sometimes seen at the hospital drawn from its local surroundings, but these are necessarily small in number, and as they are distributed over many wards and are first seen by students and transient resident medical officers they make too small an impression on the general class of patient to affect the visiting physician or surgeon, and it is he who writes on medical subjects. In acute disorders, therefore, the general practitioner sees the patient before any other professional man, and since he has to make some sort of diagnosis in order to tell how to describe the illness and determine where to send the case to, it is evident that this field is his alone and yet it is unrepresented by him in medical literature.

In chronic disorders this is, perhaps, less true, but even in these the family practitioner is usually first consulted and later, with or without his advice, a specialist is seen.

This, then, is partly why the young student is so unfavourably impressed with the outside medical man. Hospital cases are nearly always in a more developed condition, and hence are more readily diagnosed than when they are first seen. In the interest of medical science this aspect requires more detailed treatment than it has yet received, but until such a province is recognised as belonging to the general practitioner there is little hope of improvement.

(2) *An Expert in the Commoner Diseases.*—These, though less characteristic, are still a distinctive element in general practice, and what are alluded to as "slight ailments" have been, and are still, quite exclusively within this field and are scientifically perhaps the most important group of diseases to study. These slighter maladies shade almost imperceptibly into the beginnings of the more serious diseases, and where this is not so they prepare for them by weakening the resistance of the patient. The relation of repeated "colds" to tuberculosis in some form is close both in children and adults, and the gradual passage of "eccentricities" into recognised forms of insanity has never, as a subject of research, received even a small part of the attention it deserves. If the ordinary medical man were encouraged to study his cases more carefully and scientifically there can be no doubt whatever that all members of the profession would gain in knowledge as a result.

In the more pronounced illnesses such as bronchitis, consumption, nephritis, alcoholic and dyspeptic states, the experience of the general practitioner, though, of course, much inferior to the true specialist on his own line, is from a different point of view as worthy of consideration as that of the general consultant, for if he has less time to study the case at the moment of consultation he has yet followed the development of the disease in his patient for a much longer period, and he is often well acquainted with the family history and the circumstances that may have contributed to its onset. In such cases, therefore, the family medical man's opinion should receive more attention than is usually given to it, and if it is less valuable than it ought to be, this is largely due to the fact that it is so often disregarded and is consequently carelessly formed.

(3) *Environmental Influence on the Healthy and Unhealthy.*—The admission to the home of his patients, the gradual increase of friendly relations between them and himself, gives the general practitioner opportunities for research into problems of heredity, health and environmental influence that are absolutely unrivalled. He sees a patient, perhaps a young girl or boy, knows something of the parents, and sees afterwards this same patient when recovery has taken place in a few years, married and a parent. He can then trace with his own eyes influences through three, and in some cases, four generations, and he has not, therefore, entirely to rely upon mere spoken evidence, which is so often misleading. To see people under the various educational, vocational, and marital tests of life reacting differently according to different constitutions; to note differences of weather influences; the effect of poverty or of wealth, these, and a hundred other opportunities, are all before him. And it is mainly because he has not been encouraged to express his opinion that the average doctor fails to give satisfaction to his patients on many questions that they legitimately inquire about and with which our literature deals so slightly.

One may then sum up the position as follows:—The general practitioner is no longer a mere subordinate, but has his own particular sphere of investigation, due to his experience of the earliest stages of all diseases, and his exclusive study of disorders of a mild character. To this his information on hereditary endowment, personal habits, and environmental conditions must be added. It is upon such aspects of the health problem that his judgment should be sought, not only by the public, but also by other medical men (*a*), and this place in medical literature ought to be reserved for him.

It may be argued that these differences of experience should have been preceded by differences in early training. With this question I am not at present concerned, but I simply point out that whether he should or should not have been educated differently as he has in practice

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(*a*) **I have, I hope, made it quite clear that the positions of the specialist and general consultant remain unaffected by the arguments. My claims being that there are certain *distinctive* features of general practice, which, for the benefit of the medical profession *as a whole* should be better recognised.**

a different, *not an inferior*, position to the consultant and specialist it is imperative that this difference should be recognised.

A NOTE ON

FRIEDREICH'S ATAXIA AND SYPHILIS.

By GEORGE PERNET,

Assistant to the Skin Department, University College Hospital, London.

In connection with Dr. F. S. Palmer's excellent clinical lecture, which appeared in The Medical Press and Circular for May 8, 1907, I should like to be allowed to make a few remarks from the point of view of prophylaxis.

Dr. Palmer states that evidence of syphilitic transmission has been rarely traced, and adds that there are few facts recorded to support the connection. As regards the syphilis factor, I should like to call attention to the four cases recorded by A. Bayet, of Brussels, as they appear to me to be important. (1) Shortly the details are as follows. The father stated he had never had a venereal complaint. That does not go for much, histories being so fallacious. Nor had he any discoverable morbid nerve condition. The mother, æt. 44, impressionable, no definite nerve complaint. In her first marriage: two pregnancies, the first being cut short by a miscarriage; the second ending in a female child, still living. As to her second marriage: four children, the subject of Dr. Bayet's communication:

A. A boy, æt. 17.
B. A girl, æt. 14.
C. A girl, æt. 11.
D. A boy, æt. 9.
E. A girl, twin-sister, of D., but she died of convulsions.

Above followed by five miscarriages.

An examination of the father and mother did not reveal any sign or symptom of syphilis. But I should like to insist in passing on the miscarriage in the first pregnancy (first husband). One miscarriage does not make syphilis, any more than one swallow makes a summer, yet it is a fact to bear in mind. As to the five subsequent miscarriages, they do not necessarily mean syphilis; on the contrary, for in syphilis it is the rule for miscarriages to occur in the earlier stages of the disease in the mother. Although the mother exhibited in herself no signs of syphilis, that does not exclude the possibility of the infection. But when we turn to the children we find evidence of syphilis in them. In all of them there were numerous scars all over the body, apparently the result of old ulcerating lesions. In all of them again there were radiating scars at the angles of the mouth. Moreover, in B. and D. there was diffuse opacity about the cornea, and in both these patients there were ulcerating gummata, of the tonsil in B. and of the foot in D. These gummatous lesions rapidly improved on iodide of potassium. In D. there was mapped tongue, which Bayet considers is a condition that may be connected with congenital syphilis, though not constantly so. I may add here that I have frequently seen mapped tongue quite apart from syphilis; nor do I consider it has any significance in that direction.

It is not necessary to go into the details of symptoms pointing to the family disease known as Friedreich's Ataxia, but suffice it to say that A. was most affected, next in order being C., and D.; B. exhibiting but slight signs, which became significant, however, when taken with the other three children's condition. The details can be read at large in Bayet's paper. On the face of it, the probabilities are that syphilis played an important part in the production of the Friedreich symptoms, not that I desire to make out that syphilis is always responsible for that disease; possibly a variety of infections and toxæmias may lead up to it. *Primâ facie*, the mother had had syphilis, for all evidence points to so-called inherited or congenital syphilis as being communicated to the child through the mother. But that is another story, too elaborate to go into now.

My point is that when a child is the subject of Friedreich's Ataxia, careful search should be made for any clues pointing to syphilis, and the mother treated *secundum artem* by means of mercury in her next pregnancies. In women, be it remembered, syphilis turns up unexpectedly at times (2). But even apart from any positive indication, this procedure would perhaps be worth trying, in order to prevent, if possible, the development of the Friedreich condition in future offspring once a child had been affected by the ataxia. In the latter case, too, the offspring of future pregnancies might themselves benefit by the early administration of mercury to them. The cases recorded by Bayet do not appear to have had any treatment of the kind, nor does he suggest prophylactic treatment of the pregnant mother.

Bibliography.

(1) Bayet: "Maladie de Friedreich et Hérédo-syphilis." (*Jour. de Neurologie* N. 8. 1902, Bruxelles.)

(2) Pernet: The Differential Diagnosis of Syphilitic and Non-syphilitic Affections of the Skin. *Vide* pp. 5, 49, 93, 115, 160.

ON THE CHOICE OF GELATINS FOR BACTERIAL CULTURE MEDIA.

By T. THORNE BAKER, F.C.S.

Much attention has been devoted to the preparation of gelatin and other culture media for bacteriological work, but too little attention has been paid to the choice of the gelatin itself. During the past five years we have had to make a very extensive study of gelatins, and although our primary object was not the preparation of culture media, much information applicable to that work was obtained.

Gelation culture media should be perfectly transparent, and not in the least cloudy, and the jelly should be of such consistency that it does not too easily liquefy. Many gelatin media liquefy so readily that after forty-eight hour's cultivation of a liquefying organism the tubes must be watched almost hourly, as the shape and character of the growths is soon lost owing to the liquefaction.

Gelatins rich in the bony matter known as chondrin precipitate this substance during the boiling after neutralisation, and hence the filtration of the sterile medium through papier Chardin is difficult, as the pores of the paper soon become clogged; moreover, the setting power of a gelatin rich in chondrin seems to deteriorate readily on its losing this constituent.

When selecting a gelatin it is desirable to test it for acidity and for hardness. A one per cent. solution in distilled water may conveniently be used, phenolphthalein solution being added, and the necessary quantity of decinormal caustic potash solution ascertained for its neutralisation. All gelatins contain a large number of bacteria, mainly air organisms, cocci and bacilli of various sizes, but some are due to the water in which the hides are soaked; in the manufacture of gelatin the hides are steeped in water containing lime for several weeks, and a bacterial analysis we made of this water showed it to contain an excessively large number of bacteria, chiefly motile bacilli. The acidity of the gelatin depends largely upon the number of bacteria it contains, and the setting or melting point also, hence it is very desirable to choose a gelatin as free as possible from the presence of micro-organisms.

The melting point is most conveniently determined in the following way: A 10 per cent. solution is prepared by soaking ten grains of the sample in 100 ccm. distilled water for an hour, then dissolving it with the aid of heat, not, however, letting the temperature rise above 100° F. A test-tube is one-half filled with the gelatin solution, and allowed to thoroughly set, during twenty-four hours if possible; it is then laid horizontally on the shelf of a small hot-water oven, the door of which is left open, and the oven gradually heated, the thermometer being carefully watched. At some temperature between 88° F. and 110° F. the jelly will begin to melt, and the surface half-way up the tube will sag more and more until it begins to run; the temperature at which this takes place will be the melting-point of the solution.

If a specially hard medium is required, a very small percentage of chrome alum may be used provided, of course, that it does not cause inhibition or involution of the micro-organisms to be cultivated. The effect of potash and chrome alums on the melting point of a ten per cent. solution of a certain brand of gelatin was as follows:—

	Quantity per cubic centimetre.	Melting Point.
Potash alum ..	.0024 gm.	97·5° F.
,, ..	.0048 ,,	102.0° F.
Chrome alum ..	.0003 ,,	119.5° F.
,, ..	.0006 ,,	133.0° F.
,, ..	.0010 ,,	above 180° F.

It may be assumed that the resisting power to liquefaction by bacteria is directly proportional to the melting point.

Coignet, Drescher, Heinrich, Simeon, Koepff are the principal continental makes of gelatin; Heinrich's brand the hardest as far as our tests have shown; Nelson and Luton are the English makes of first importance, and the latter needs special mention, since it is unusually free from bacteria, and its melting point is high; it is also exceptionally transparent and filters readily. In many instances where we have had to make several sub-cultivations without examination, we have used a medium prepared by adding one grain per cent. each of somatose and peptone, ·5 gm. sodium, sodium chloride and ten grains Luton gelatin, neutralising and boiling for thirty minutes. The medium has been so clear that no filtration has been necessary and it has proved satisfactory for all organisms so far experimented with; the low percentage of chondrin in this gelatin is also in its favour.

At Guy's Hospital Mr. F. Newland-Pedley, F.R.C.S., L.D.S., has been appointed consulting dental surgeon to the hospital; Mr. H. L. Pillin and Mr. M. F. Hopson dental surgeons; and Dr. J. W. H. Eyre bacteriologist.

SOME FURTHER REFLECTIONS
ON
CANCER AND ITS TREATMENT.

By J. A. SHAW-MACKENZIE, M.D.Lond.

The local atrophy and degeneration of a cancerous growth induced by subcutaneous injections of trypsin in the neighbourhood of a tumour or into the substance of the tumour itself cannot be accepted as evidence of the successful treatment of cancer. This statement is based upon the experience of actual facts as proved in cases which have been under my care, or which have come under my observation. Moreover, in a large number of cases the growth itself is inaccessible to local injection. Again, in the instances in which direct injection into the tumour or into its periphery has been practised—a method of treatment I have never personally recommended—the extreme amount of physical suffering has been the invariable result.

Presuming, as I have done, that the causative factor in the cell proliferation of cancer was a deficiency of trypsin, the natural inference seemed to be that the difficulty of reaching inaccessible growths would be met by injections of a solution of trypsin at a distance from the growth, the assumption being that the trypsin would reach the site of disease through the circulation, or supplement the general deficiency underlying its manifestation. But that assumption does not now seem so easy of acceptation, inasmuch as this method of administration does not accord with the view generally admitted that the blood possesses or acquires certain anti-tryptic properties.

(1) According to S. G. Hedin, (*a*) normal serum has a decided anti-tryptic action, and trypsin and its anti-body undoubtedly in more than one respect behave in a way similar to some toxins and their anti-bodies. He shows moreover that the anti-body can be completely saturated by using a sufficient amount of trypsin, though on the other hand it has been found impossible to completely neutralise all trypsin by an excess of anti-body. Attention has recently been drawn by more than one observer to this view, viz., that trypsin acting as a toxin, the production and use of its anti-body cannot be lost sight of in the therapeutic employment of trypsin in the treatment of cancer.

As long ago as November, 1905, Mr. F. W. Gamble drew my attention to this aspect of the problem. He advanced the opinion that the deficiency or absence of trypsin would imply the non-production of its anti-body, a substance which might be regarded as physiologically essential, the absence of which might conduce to cell proliferation. In such cases, trypsin, regarded as a toxin, if injected in too large doses, would damage the cells before they were able to produce its anti-body, whilst small doses would bring about a considerable increase of anti-tryptic power. In accordance with this view, he further observed that the reaction of individuals to trypsin might differ according to their capacity to produce its anti-body, while, even in some this capacity might be absent, necessitating the resort to the administration of anti-bodies, prepared after the well-known methods for obtaining anti-toxic sera.

The question of dosage and the proper control of this toxic agent, therefore, as also from the first, have claimed my most serious attention, and in proof that such caution is necessary, coma, following injections of trypsin, has been reported to me in at least two cases in the actual practice of others. In other cases it has been obvious that reaction, both locally and in the tumour itself, varies in different individuals, the dosage and strength of the solution remaining the same. In truth, my experience has taught me that each case can only be treated, so far as the dosage of trypsin is concerned, in accordance with its special requirements, that is to say, that in some more trypsin is requisite, in others less. Moreover, in a certain proportion of cases my experience has taught me that trypsin is contra-indicated, as proved by the apparent advance of the disease instead of its retrocession, through trypsin having unfortunately and inadvisedly been given to the patient.

I have myself attempted to draw a clinical differentiation between those cases of carcinoma in which glycosuria is present, or a history of diabetes is present in one or other member of the same family and those in which it does not obtain, but rather a long history of constipation or gall stones. In the former, the "liver or pancreas" (*b*) is presumably at fault (glycogenic theory) and trypsin indicated; in the latter, the liver (cholesterinic theory) and the method of treatment introduced by Mr. J. H. Webb by sodium oleate injections and oral administration of purified ox gall, indicated. Furthermore, my impression is that in cases in which there is a "specific" history, trypsin is not indicated. I desire to lay particular stress on these points because it seems to have been assumed by many that the administration of large doses of trypsin is a method which I advise, and that I recommend trypsin alone to the exclusion of other methods of treatment.

For some considerable period a large number of examinations of the opsonic index of the blood to *m. neoformans* has been made for me by Dr. Aylmer May, and by Dr. J. C. Matthews, in patients undergoing the trypsin treatment under my care. From these examinations it has been shown that the index may be raised slightly but for the most part remains normal, in contradistinction to the irregular and characteristic indices in cases of advanced and untreated carcinoma; in other words, auto-inoculation appears to be prevented, coincident with freedom from fœtor and pain. They have seemed to show also that in certain cases the dosage might be increased. How far these results may be due to chian turpentine injections—a method of administration originally introduced by Col. T. Ligertwood, C.B., M.D., and myself (*c*), and which I generally use in addition—I cannot say. At the same time these examinations have not shown the characteristic curves witnessed in cases after inoculations of the *m. neoformans* vaccine. It has seemed obvious from this that the increased leucocytosis, following the use of chian turpentine injections, which I have demonstrated, bears no relation to the opsonic index; that whereas by analogy to other toxins the trypsin injections should be "interspaced," the index to *m. neoformans* is not the "tryptic" index.

In this regard, I may point out that the treatment of inoperable cancer by the method of Sir A. E. Wright (*d*) with vaccines of the *m. neoformans* controlled by its opsonic index, coupled with the probability, as it seemed to me, that this micro-organism belonged to the tryptic group, led me to consider that the same control might be applicable to the trypsin injections. (*a*) The results show, however, that the tryptic index must be sought for in other directions. For example, a direct method of estimating the tryptic or anti-tryptic power of the blood *in vitro* has been introduced by Sir A. E. Wright, and it will therefore be possible to determine not only the normal anti-tryptic value of the blood under different conditions, but also the action of trypsin administered subcutaneously, and its precise dosage. In this connection it may be pointed out that the digestive properties of leucocytes are considered by Sir A. E. Wright to be due to a ferment apparently identical with trypsin.

(2) There is, however, another aspect of this question which cannot be lost sight of - viz., the natural production of trypsin in the body and its aids.

Admitting that a presumed deficiency in the intestinal tract may be supplemented by the therapeutic employment of trypsin orally; recognizing beneficial local and general effects by its local application and introduction into the circulation by one means or another, the problem of treatment, in all probability, resolves itself into the best means of increasing its action or its production in the body or tissues.

It is known that the stimulus of food and acids excites the alkaline saliva. This promotes the gastric acidity, and the acid chyme in turn excites the alkaline secretions of the pancreas, liver and intestinal glands. The supply is regulated by the demand till equilibrium is established. Professor E. H. Starling, in the Croonian Lectures on "The Chemical Correlation of the Functions of the Body" (*The Lancet*, August, 1905) not only drew attention to this mechanism, but showed that the pancreas is stimulated to secretion, chemically, by the substance secretin, while the trypsinogen of the pancreas is converted into trypsin by the ferment of the intestinal glands. Professor B. Moore (*e*) has shown that the presence of free hydrochloric acid in the gastric contents is diminished or absent in cases of malignant disease of organs other than the stomach. Obviously, therefore, inhibition of the pancreatic, liver and intestinal functions follows on the diminution or absence of the gastric acidity. It is known also that ingestion of hydrochloric acid doubles the amount of the pancreatic secretion (*f*), though the secretion itself is devoid of proteolytic qualities till activated by the intestinal juice, the activity being still further increased by the bile.

Such considerations no doubt in part explain the value of hydrochloric acid recommended as treatment in cases of carcinoma no less than the beneficial results obtained by my recommendation of preparations of the intestinal glands and further administration of the bile salts. The power of the intestinal secretion, however, does not end here, for it plays an important *rôle* in carbohydrate metabolism.

A similar adaptation or correlation in all probability takes place in the tissues themselves. As Professor Starling has pointed out, the stationary condition of any given cell is the result of equilibrium between two sets of processes, one causing a building up of the cell, the other a breaking down. Dr. H. M. Vernon (*g*), to whose researches on another and, in all probability, the most important proteolytic ferment of the body, erepsin, universally present in animal tissues, and common to all animal tissues and organs, I have elsewhere drawn attention (*h*), holds that probably the various intra-cellular proteolytic ferments, whether those acting in an acid medium or those acting in an alkaline, form a fairly constant constituent of each individual tissue. In this respect quantitative comparison is made between the lineo-β-protease or proteolytic ferment, which acts in an acid medium (S. G. Hedin), and erepsin or proteolytic ferment, which acts in an alkaline.

The first class of adaptations noted by Professor Starling includes those reactions of the body to chemical poisons produced by bacteria, "and represents one of the most important means by which the body maintains itself in the struggle for existence." Such adaptation, correlation, and reaction is witnessed, as it seems to me, in the increase of ereptic power of the tissues in septicæmia (one case) and in miliary tuberculosis (one case) noted by Dr. Vernon.

The same increase exists in carcinoma. As far as the limited number of cases indicate, noted by Dr. Vernon, in two cases of cancer (stomach, bladder), the ereptic power was markedly increased in the kidney, liver and cardiac muscle; in a third case (secondary, liver) an increase was observed in the liver tissues alone. In this it would seem to me that we have a condition comparable to the adaptation, correlation and reaction of the healthy tissues to bacteria and their toxins and opsonins. Viewing the autolytic acid ferment (or ferments) of cancerous tissues (Petry; Blumenthal; "peptic," (J. Beard) (*i*) as a toxin it would appear as it seems to me to call forth the ereptic ferment irregularly, uncontrolled and unequal to the demand, save in rare instances of spontaneous cure. Presuming initial, local or general deficiency of the ereptic ferment in carcinoma, as well illustrated in a fourth case (rectal) noted by Dr. Vernon, in which presumably also the tissues were not capable of reaction, preparations of the

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(*a*) Since the above was written I have received an interesting letter from Dr. D. Montgomerie Paton, of Melbourne, in which the question of anti-bodies and anti-trypsin is considered. His view is that by trypsin injections and the use of it and other digestive agents orally, an ACTIVE resistance to the *m. neoformans*, which he regards as a variety of staphylococcus, in some measure may be obtained, whereas by the oral use of anti-diphtheritic serum, which he has long advocated in carcinoma and in some bacterial infections, a similar result is obtained, PASSIVELY. He demonstrates the passive raising of the opsonic index to staphylococci by the action of normal and immune serums, orally administered, and believes that trypsin injections would do the same actively. (Vide "New Serum Therapy," by D Montgomerie Paton. Bailliere, Tindall and Cox, London.)

intestinal glands and liver rich in this ferment were made for me by Mr. F. W. Gamble for therapeutic use in the treatment of cancer, in the same way as originally he prepared trypsin injections (Allen and Hanbury's) and pancreatic preparations. (*j*).

In this connection it is of interest to note that Professor von Leyden, of Berlin, holds that cancerous growth is due to insufficiency of a proteolytic ferment of the liver.

In originally drawing attention to the increased ereptic power of the tissues noted by Dr. Vernon in the above cases, I suggested also that it might be compensatory to an increased autolytic acid ferment. The converse position cannot be lost sight of, viz., that this increased autolytic condition of the tissues may be correlated or adapted to an increased alkalinity. If so, by analogy with the mechanism of peptic secretion a direct stimulus, psychical, or amylolytic, may be presumed. In such respect Dr. Francis Hare notes in his work "The Food Factor in Disease," section 708, "a chemical, bio-chemical, or metabolic hypothesis for the etiology of cancer" in referring to the work of John Rogers, Junr. (New York), that "it has been known for some time that cancerous tissue contains enzymes, but Dr. Buxton, of the Cornell Medical College, has shown that the most abundant and constant enzyme present is the amylolytic. Conformably, glycogen is found in all tumours in a quantity varying directly with the malignancy of the disease." Again, on the other hand, according to M. Hartog (*k*), in addition to a saccharoid substance, a peptonising ferment, active only in presence of dilute acids, is present in the developing blastoderm of the chick, and Dr. Vernon notes that the ereptic power of the tissues of the guinea-pig, rabbit, and cat, is at a minimum in the earliest stages of development; that it increases steadily during intra-uterine life and for the first few days of postnatal existence, after which it remains constant.

It would appear, therefore, that from the earliest stages of development the intra-cellular proteolytic ferments which act in an alkaline medium are adapted or correlated to those which act in an acid medium; that chiefly associated with failure of the alkaline proteolytic ferments, due to various causes, local, congenital, or advancing years, reversion to the peptonising ferment, which is active only in presence of dilute acids, obtains, whilst cell proliferation proceeds in the presence of glycogen and amylolytic ferment, for the latter by itself is unable to break up the proteid-glycogen molecule of the living tissues, or still further in the absence of the intestinal ferments convert maltose into glucose.

Not long after the appearance of Professor Starling's lectures, in which he further concludes that the growth of the mammary glands during pregnancy was due to the assimilatory, building up, or inhibitory effects of a specific hormone or stimulus produced in the fœtus, I received a letter from Mr. J. H. Webb, of Melbourne, to whose original work (*l*) on the treatment of cancer I have so often drawn attention.

He wrote that he had read Professor Starling's lectures in the *Lancet* with the greatest interest; that some eight years previously he had seen a woman suffering from a large intrathoracic, sarcomatous growth involving the shoulder, and pushing the scapula out of place. She did not suffer much acute pain, but she had considerable dyspnœa, and the heart was displaced; it was of course inoperable, and he treated her with freshly prepared animal fœtal extracts. To his astonishment the tumour began to slowly diminish; in about a year's time it had entirely disappeared and eight years later the patient was apparently in perfect health, though the superficial veins remained dilated. He remarked that though one case goes for little, he fancied the remedy for sarcoma must be in the fœtal tissues. In this case it is not improbable that in thus administering an acid extract he may have been administering a fœtal secretion, and that one or other excited the dissimilatory, breaking down, ereptic, or tryptic ferment in his patient. In this connection it is of interest to note that in some rare instances the occurrence of pregnancy has been known to arrest, even to cure, pre-existing carcinoma in the mother. The admitted fact of spontaneous arrest and cure of the disease not connected with pregnancy, inspires the hope that, if so, "it is by no means improbable that the curative process may be forwarded by a recourse to those measures with which art is furnished."

Regarding therefore the alkaline proteolytic ferments as defensive factors, and the cell proliferation of cancer due chiefly to their deficiency or absence, the proper method of administration would seem to be the use of small doses subcutaneously, with larger doses orally; or alternatively, and suggestively the opposite, viz., the use of the acid toxins of the tissues, animal fœtal extracts, or of the growth itself.

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OPERATING THEATRES.

ROYAL FREE HOSPITAL.

TWO OPERATIONS FOR APPENDICITIS AFTER SUBSIDENCE OF ACUTE SYMPTOMS.—MR. JAMES BERRY operated on a boy, æt. 15, who had been admitted nineteen days previously on the third day of a very acute first attack of appendicitis with peritonitis. On admission his temperature was 100.4, pulse 128, the abdomen tender, rigid and painful; vomiting also was present. He was kept quiet in bed, purgatives and enemata were avoided, care was taken not to give any food by the mouth for the first ten days. All the acute symptoms rapidly subsided and operation was now undertaken, as Mr. Berry pointed out, at a much more favourable period, than on the patient's admission there being at present no acute symptoms of any kind. On opening the abdomen, numerous recent slight adhesions over a large portion of the abdomen afforded abundant evidence of the extensive peritonitis that had existed when the boy was first seen. The appendix was found deeply seated below the cæcum; the tip was firmly adherent, perforated, and surrounded by a small abscess cavity, evidently the remains of the previously widespread inflammation. Removal of the appendix presented no difficulty and the wound was closed without drainage.

The second case operated on was similar, but much less severe. The patient was a woman, æt. 24, who had been admitted on the second day of her fourth attack of acute appendicitis. The present operation was performed eight days after admission, when the temperature and pulse, which on admission had been 101 to and 108, had both fallen to normal, 96 and 70. The intervening treatment had been similar to that employed in the preceding case. At the operation the appendix was found greatly thickened, adherent, perforated, and connected with a small abscess. The mesentery was tied, the whole appendix removed, and the stump buried in the cæcum by means of a purse-string suture. The wound was closed without drainage. Mr. Berry said that this was a method he employed in the vast majority of cases of acute appendicitis in his wards. He thought that operation was very rarely needed in most cases of acute appendicitis during the acute stage, provided they were properly treated from the beginning. Absolute rest in bed, no food by the mouth for the first few days, and abstention from purgatives and enemata were the main points in the treatment. The injudicious and indiscriminate use of purgatives and enemata he considered responsible to a great extent for the modern mortality of the complaint, whilst he was afraid that indiscriminate and hasty operation undertaken in the early and acute stage was also responsible for a good deal of it. Localisation of the inflammation would be found to occur in nearly all cases, provided the parts were kept strictly at rest, and this was not possible if they were frequently irritated or disturbed by purgatives and enemata. He thought that when the inflammation had become localised operation could be undertaken with much less danger to the patient and a far greater prospect of a successful issue. There were, however, a few—a very few—cases of acute appendicitis in which immediate operation was demanded—cases of so-called fulminating appendicitis, cases of sudden rupture of an abscess, cases with acute intestinal obstruction, and some few cases of general peritonitis. In the latter condition, however, the less done at the operation the better, a small incision being all that is usually required.

It is satisfactory to state that a week after operation both patients are doing well in every way.

TRANSACTIONS OF SOCIETIES.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held Friday, July 12th, 1907.

The President, Mr. Priestley Smith, F.R.C.S., in the Chair.

Dr. Fukala, of Vienna, read a paper dealing with the

TREATMENT OF A VARIETY OF EYE CONDITIONS.

For marginal blepharitis he advocated an 8 per cent. to 10 per cent. solution of silver nitrate applied to the edges of the lids daily, care being taken that none of the solution enters the eye. For scleritis, both of the superficial and deep types, he recommended the daily application of a 1 in 4,000 solution of perchloride of mercury. The procedure being to first anæsthetize the eye by cocaine, and then with a pledget of cotton wool dipped in the solution to gently rub the sclerotic with a circular movement around, but not touching the cornea. This was thought to influence the ciliary blood vessels. Similar treatment was stated to be effective against chondritis with vitreous opacities, and also occasionally against embolism of the central artery of the retina.

Mr. W. H. Jessop read a paper on three cases of

ACUTE UNI-OCULAR OPTIC NEURITIS

in boys, accompanied by great loss of vision and complete recovery. The cases were three public school boys, æt. 12, 17 and 14. In each there was in one eye marked papillitis, the swelling of the optic disc being about 1 mm., and the vision was reduced to counting fingers. No cause could be found in two of the cases; but in one of them two months after the commencement of the papillitis an abscess discharging a quarter of a pint of pus broke into the rectum. He was operated on afterwards for appendicitis. The probability is that all cases are due to toxæmia. In each case the acuity of vision returned to the normal, in two patients after two months, and in the third after four months. In two cases there was a marked central scotoma, and probably also in the third. So that besides papillitis there was also retrobulbar neuritis. The treatment adopted was mercurial inunctions, iodide of potassium and protection of eyes by peacock green glasses. The great point is the prognosis, as though the vision is much reduced there is complete recovery with normal acuity of vision and normal fields, but the optic nerves remained slightly pale.

In the discussion on this paper, in which Messrs. Marcus Gunn, W. Holmes Spicer, Arnold Lawson, J. Taylor, and others joined, several similar cases were mentioned. The condition was held to be one of retrobulbar neuritis, possibly upon a toxæmic basis, and the prognosis on the whole good, with little or no diminution in visual acuity.

Mr. A. Lawson showed a case of "Thiersch grafting for symblepharon, the result of pemphigus seven years after operation." The left eye has kept well, and although some slight shrinkage has gone on, movements and vision remain good. In the right eye the shrinking process went on somewhat more rapidly, so that two years ago it was necessary to do a further grafting operation, since when the eye has remained well.

Cases were also shown by Messrs. L. V. Cargill ("Solitary Quiescent Tubercle of the Choroid"), S. Stephenson ("Curious Ophthalmoscopic Change"), and A. McNab ("Congenital Opacity of the Cornea in three members of one Family").

ROYAL SOCIETY OF MEDICINE.

The Therapeutical Section on Saturday, July 6th, met at Oxford University. The visit was arranged for the Therapeutical Society before it dissolved, and much regret was felt at the absence of Dr. French, who was hon. secretary of that Society, he was prevented from being present through illness, from which he is happily now recovering.

The members were received at the entrance to Queen's College by Sir Thiselton-Dyer, the first president of the old Society. After a glance at the buildings and some of the other colleges, he conducted the party to the Museum, where Professor Osler was already waiting ready to point out the beauties of the library and show the way to the laboratories.

The first visited was that of Professor Gotch, who explained some of his most recent investigations of the action of the heart. He pointed out that his predecessor, Professor Burdon Sanderson, had conducted his experiments on the empty heart, which revealed that the ventricular contraction began at the base and terminated at the apex. However, Professor Gotch has by delicate electrical experiment on the active heart *in situ*, shown that the contraction commences at the base, travels to the apex and terminates at the aortic base, this was graphically displayed, and many interesting diagrams and photographs were shown.

He next demonstrated a means of at once determining the point of near vision of anyone, the method depending on the different focal lengths of the red and violet rays.

Dr. Ramsden in the same laboratory had arranged a number of beautiful experiments, which he described determining the "Separation of Solids in the Surface-layers, of Solutions and Suspensions."

Proceeding to the Anatomical Rooms, Professor Arthur Thomson showed a thorax with complete transposition of the viscera; and a dissection of a calf's heart displaying to perfection the auriculo-ventricular bundle (Hiss), and demonstrating how important a structure it is; also some enlarged photographs (stereoscopic) of the very early human embryo.

In the Pathological Rooms there was an exhibition of macroscopic and microscopic specimens, and Dr. Gibson gave a demonstration of Jacquet's Polygraph (modified) on a lad.

Lunch followed in Queen's College, and in the afternoon many places of interest including the Botanical Gardens were visited.

Professor Osler gave a garden party at his home, to which all were invited, he had laid out for inspection some of his choicest, rare and interesting folios, which everyone thoroughly enjoyed the privilege of examining.

The Section dined in the evening at Queen's College. Sir James Sawyer proposed the health of the President, Dr. T. E. Burton Brown, C.I.E., he referred to the good work done by the Society of which he was the "Father," remarked on the fitness of seeing him president of the new Section, and hoped for greater things in the future.

Dr. **Burton Brown** replied and thanked the officials of Queen's College for their courtesy in inviting the members to that College, and in placing rooms at the disposal of those who desired to remain until Monday.

Dr. Cecil Wall, through whose good offices the visit was rendered possible, acted as cicerone, and showed every attention and kindness to the party.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, July 14th 1907.

Treatment of Metritis.

For cauterising the cavity of the uterus, liquid caustics are preferable to solid caustics. They should be applied by means of a plug of cotton, wet with a solution of iodine, 6 dr., phenic acid 4 oz., glycerine, 8 oz.; or chloride of zinc, 1—2; nitric acid; pure phenic acid; formol, 1—3.

Curettage, according to Pozzi, is the rational treatment of chronic metritis where the simple treatment (vaginal and intra-uterine injections) fails, and should not be delayed too long for fear of exposing the parenchyma of the uterus to follicular degenerescence, and the possible propagation of the lesions to the tubes.

Certain authors, on the contrary, consider the operation of curettage absolutely counter-indicated. "Curettage," says Marion, "should be prescribed in non-hæmorrhagic acute, or chronic metritis, and in cases where hæmorrhagic metritis is complicated with lesions of the Fallopian tubes."

For Professor Loubeyran, the operation was only indicated in those cases of chronic metritis, where all other treatment had been given a long trial and without success.

Ulcerations of the os should be touched every two days with tincture of iodine, weak nitric acid, or chloride of zinc, 1-10. After cauterising, the vagina should be irrigated and a plug of antiseptic gauze inserted. Where the cervix was much jagged or hypertrophied from follicular degenerescence, the parts should be excised.

Hæmorrhagic metritis is best treated by rest in bed, prolonged vaginal injections with very hot water (122° F.), and the administration of hydrastis canadiensis, viburnum prunifolium, hamamelis virginica, or ergot of rye. If the hæmorrhage does not cease, plugging of the vagina with antiseptic gauze will be necessary.

The operative treatment is reserved for the cases where retention of the placenta is suspected. The os is dilated and the cavity irrigated, after which a digital curettage is made, or, if necessary, a curettage. In case of degenerescence of the mucous membrane, curettage is also necessary. In rebellious cases, hysterectomy should be performed.

For chronic painful metritis, the cervix should be painted, two or three times a week, with the caustics above-mentioned and plugs of glycerine or ichthyol applied. Hot vaginal injections and scarifications of the os are very useful. Where every treatment fails, hysterectomy is the only resource.

The Paralysis of Diphtheria.

According to Professor Comby, the most efficacious treatment of paralysis as a complication of diphtheria is that of injections of the serum of Roux. It always succeeds if employed promptly. Three drachms should be injected each day until improvement takes place.

A Differential Sign of the Origin of Pain.

Pain is either of organic or psychic origin, and frequently the distinction is difficult. M. Lorvi observed that the dilatation of the pupil was in direct relation with painful sensations. In the healthy man, if strong pressure is made on the testicle, this sign is observed, while in an individual suffering from ataxy, where the testicle is insensible, dilatation of the pupil is not observed.

According to the same author, dilatation of the pupil produced by pain allows distinction to be made between pain of organic origin and that of hysteria.

Another author made numerous experiments along these lines and came to the same conclusion. In healthy persons, the painful reflex invariably existed, the dilatation of the pupil was affected more or less rapidly, according to the intensity of the pain itself, and after the cessation of the pain, the pupil returned slowly to its first dimensions.

In pneumonia, pleurisy, articular rheumatism, sciatica polyneuritis, Pott's disease, appendicitis, ulcer of the stomach, pressure exercised on the painful regions provoked dilatation of the pupil.

On the other hand, in ten cases of hysteria, no enlargement of the pupil was observed when pressure was made over the usual points. Similar negative results were observed in two patients suffering from chlorosis, and eight men affected with traumatic neurosis.

The above facts are of great importance, as by them a distinction can be made between the characters of pain.

GERMANY.

Berlin, July 14th, 1907.

At the German Society for Surgery, Hr. Riesinge read a paper on the

Operative Treatment of Dilatation of the Œsophagus.

He showed a patient who for twelve years had suffered from a deeply-situated diverticulum of the œsophagus. The patient, a female, often vomited in the following morning the remnants of the dinner of the day before, whilst the food of the evening before did not come up. Of two sounds introduced, one, usually the thicker, reached the stomach readily; the other generally passed for a distance of 32 cm. below the line of teeth, but no farther. A Röntgenogram when the œsophagus was filled with a bismuth porridge showed a wide shadow reaching from the second dorsal vertebra to the œsophagus, the lower end of which distinctly bulged out to the right. An operation was decided on on account of the patient's starved condition and the great discomfort caused by the diverticulum. After a preliminary gastric fistula had been formed the whole œsophagus was exposed from the posterior mediastinum; resection of a portion was performed 7 cm. in length from the fourth to the seventh rib, the pleura was separated from the lateral surface of the spine, and the œsophagus was isolated almost to the diaphragm; the pleura was not injured. It was intended to diminish the lumen of the œsophagus by forming folds, but the patient's collapse prevented this. The extensive wound was tamponnaded. After several weeks a strip 15 cm. in length and 1-2 in width was excised; the suture was done in two stages. The operation was quite successful; swallowing was undisturbed and the vomiting ceased.

Hr. Schmitt (Munich) reported a case of

Complications after Resection of the Stomach.

The cases were rare. (1) An extensive resection of the pylorus was performed for carcinoma after Billroth's method. Recovery was uninterrupted, and increase of weight took place. A year and a half afterwards the patient got double pneumonia after a very violent long coughing bout. A small red fluctuating spot formed in the cicatrix of the abdominal wound and opened of itself in a few days, whereupon a large quantity of bile escaped. Within a few days a complete fistula formed from the stump of the duodenum with casting off of the ligature placed there a year and a half before. Gastric digestion remained undisturbed. After freshening the edges, turning in and suturing, healing took place. Probably in consequence of the violent coughing a backward movement of the bile had taken place between the sutured end of duodenum and the gastric fistula, whereby infection of the bile possibly took place. He had seen fistulæ occur twice after such resections of the stomach; lately he had therefore preferred Kocher's method where technically possible.

(2) Total necrosis of the omentum invaginated into the colon with secondary fistula. Extensive resection of the stomach after Kocher's method had been performed with good recovery and good action of the bowels. Three weeks after the operation the abdominal wound opened and a large piece of omentum the size of the hand was cast off. For the next week the evacuations were normal; then suddenly great distention took place on the right side of the abdomen. A small shred of necrotic tissue showed at the opening. On slight traction on the piece of tissue a lump the size of an apple was expelled as by an explosion. This was followed by a great quantity of gas and fæces forcibly expelled. The fistula of the transverse colon closed of itself. The omentum first became gangrenous three weeks after the resection of the stomach, and it had worked its way into the transverse colon which, however, performed its function normally until complete occlusion of the bowel took place. It reminded the speaker of the wanderings of foreign bodies in the intestines.

AUSTRIA.

Vienna, July 7th, 1907.

Cardia-Carcinoma of Stomach.

Eiselberg presented a man, æt. 36, who came to the clinic suffering from inability to swallow food. The sound was applied, but would go no further than the upper part of the cardiac end of the stomach, no matter how fine the sound. Notwithstanding this mechanical inability to pass a sound the patient could sometimes pass food into the organ in the usual way. Carcinoma of the œsophagus was at once diagnosed, but when the weight of the patient was considered, and that he had lost only 9 kilos, or 19 lbs., in two years while this had been going on all the time, such a conclusion as carcinoma was doubtful.

Could it be a "Divertical," forming a sac in the wall of the œsophagus? The patient was given a solution of bismuth, and the Röntgen rays applied, when a large sac of enormous distention was discovered immediately above the cardiac end of the stomach in the œsophagus. Considering the loss of flesh and the probable increase in this direction, the longer it was allowed to remain, Witzel's form of gastrostomy was resolved on as the best operation for this case. After the patient had rested in hospital for a time and appeared to recover, the œsophagoscope was again applied to confirm the diagnosis of a diverticulum in the œsophagus, but nothing further could be discovered. The day before the operation, another examination was made with the rays, when a well-defined sac was observed at the cardiac end of the œsophagus in form of a finger pointing towards the stomach. As no opening from the œsophagus could be detected either by the instrument or the rays, it was now doubtful if the diagnosis were correct, as it might be dilatation caused by spasms of the œsophagus. After comparing the first radiograms with the last, the spasm theory was abandoned and the operation performed. After making the fistular gastrostomy, spasm in the lower end of the œsophagus did set in and complicated the results, so that after another three weeks laparotomy of the stomach had to be performed. The hand was then entered and the œsophagus explored. At first a very fine catheter could only be inserted, which was gradually increased until the thumb could be passed, and after it was fairly dilated the organ was closed and healed up favourably. A No. 24 bougie can now be passed easily by the mouth into the stomach and deglutition is normal.

Contractional Phenomenon of the Stomach.

Kaufmann, from his experiments on animals, distinguishes two separate functions of the stomach occurring one in the cardiac and the other in the antral portion of the organ between which a constricting ring actually makes two water-tight compartments. The antral portion is much more active and vigorous than the cardiac. He found that the food taken into the stomach was concentrated and rolled together in the cardiac end and almost covered with a fine mucous coating, while the fluid was quickly transmitted to the antral portion. To obtain this phenomenon he injected physostigmine, which acts and stimulates the smooth fibres of the stomach and alimentary canal. This produces three contractions (*a*) circular motion, (*b*) longitudinal, and (*c*) cardiac and antral.

Kaufmann considers this an important factor in all operations on the stomach and particularly in gastro-enterostomy, where the functional part of the organ should be considered whether in the cardiac or antral portion.

LETTERS TO THE EDITOR.

THE THERAPEUTICS OF HARROGATE WATERS.

To the Editor of The Medical Press and Circular.

Sir,—I have lately noticed persistent statements in several newspapers hinting at the diminution of the effects of Harrogate waters, and *The Illustrated Journal of Health Resorts*, May–June, 1907, in particular, has published some misleading data regarding the constituents of the waters, and comparing them with several other spas, gives an erroneous statement of their strength and composition.

Under these circumstances I have been prompted to go into the matter, and will show that so far from there being any material alteration in the waters they have not changed in any appreciable degree for a great number of years.

Having compared the different analyses given in the journal referred to, I drew the attention of the authorities here responsible for the management and distribution of the waters, and they have given me sufficient statistics to prove my case.

Allow me to place alongside each other the statement made by the Journal, and an analysis made by the eminent chemist, Professor J. E. Thorpe, C.B. :—

PROFESSOR THORPE.

Saline Constituents Grains per Gallon.	Old Sulphur Well Pump Room	*Health Resort* STATEMENT.
Sodium Sulphydrate ..	5.215	6.50
Barium Chloride	6.566	
Strontium Chloride ..	trace	
Calcium Chloride	43.635	16.75
Magnesium Chloride ..	48.281	17.75
Potassium Chloride ..	9.592	
Lithium Chloride	.753	
Ammonium Chloride ..	1.031	
Sodium Chloride	893.670	.236
Magnesium Bromide ..	2.283	
Magnesium Iodide ..	.113	
Calcium Carbonate	29.768	
Magnesium Carbonate ..	5.953	
Sodium Carbonate ..	..	11.
	1047.561	288.
Sulphuretted Hydrogen	10.16	
Carbon Dioxide........	40.10	
	50.26	

In the first place it will be noticed that the sum total of grains per gallon does not agree with the sum of the different constituents, and as the Journal apparently quotes an analysis by Mr. West, I find the total amount given by him in the official record is 1047.01, and not 288.0–.

The amount given by Professor Thorpe (at a later date than Mr. West's analysis) is 1047.01, so that it can be seen at once that the statement contained in the Journal is entirely wrong, both in total and individual constituents, thus seriously misrepresenting the strength of the Harrogate waters.

Might I be allowed to give a list of the analyses given by leading men since 1794, which shows that the strength of the waters has been consistently maintained, and also that the salts in grains per gallon have scarcely varied during the last seventy years, and they now appear to be as reliable and efficient as ever.

OLD SULPHUR WELL ANALYSES :—

		Total Salts in Grains per gallon.
1794	Dr. Garnett	754.0
1819	Sir C. Seudmore	848.10
1830	Dr. Hunter	1010.5
1844	Mr. West	1047.0
1854	Professor Hoffman	1096.0
1867	„ Muspratt ..	1108.78
1875	„ Thorpe... ..	1047.01
1881	Mr. Davis, F.C.S.	1048.25
1899	„ Townsend, F.C.S. ..	1025.4

In fact without wishing to appear presumptuous it may be fairly said that taken as a whole the treatment here now (waters and baths included) will favourably compare with any other spa, either British or foreign.

I am, Sir, yours truly,
D. D. BROWN, M.R.C.S., L.R.C.P.Lond.
Harrogate.

DENTAL AND COSMETIC QUACKS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am glad that in the fight against quackery—the attempt to expose the whole system before a Royal Commission—dental and cosmetic impostors are not to be overlooked. If the operations of these rogues did not, as they certainly do, inflict injury upon health, it would be still the duty of the State to guard simple and foolish women, the majority of victims, against the robbery, the system of thinly veiled blackmail, which it often really constitutes, and to which they are now helplessly exposed. The safety of this species of quack lies in the fact that there is hardly any maltreatment a nervous woman would not condone rather than expose her folly publicly in a Law Court, as plaintiff in an action for damages. The quack, moreover, in the few cases when pressed, always refunds his plunder and pays damages rather than go into court ; hence exposure of this nefarious traffic is now never effectually made. It cannot be made without the help of a Royal Commission. Within the past few weeks there has been published in a medical paper analyses of fat cures, under cloak of selling which many quacks are making fortunes. These cures, when not made up of slightly perfumed fat, were composed of water strongly acidulate with the cheapest of chemicals. Retailed at about 2s. 6d. an ounce, the intrinsic value of this mixture of which the uselessness for its purpose could be easily demonstrated, was a small fraction of a farthing. The cheap artificial tooth fraud could be as easily exposed. If the Food and Drugs Acts and the Merchandise Marks Acts have been devised for prevention of much less dishonest practices in trade, is it too much to ask the Legislature to protect the public against the far more hurtful forms of medical fraud which you, Sir, are exposing ? It is to be hoped that Mr. Sewill's suggestion of a Royal Commission will speedily be taken up by professional organisations.

I am, Sir, yours truly,
A HOSPITAL DENTIST.
July 13th, 1907.

OBITUARY.

SIR W. H. BROADBENT, PHYSICIAN-IN-ORDINARY TO THE KING.

WE regret to record the death, on the 10th instant, of Sir William Henry Broadbent, K.C.V.O., M.D., F.R.S., Physician in Ordinary to the King, at his house in Brook Street, London. Sir William Broadbent, some nine months ago had a severe attack of influenza, which was followed by an attack of pneumonia and empyema, necessitating an operation. From this illness his recovery was slow, and he never resumed his active occupation.

Sir William was a son of the late Mr. John Broadbent, of Longwood Edge, was born in January, 1835, and received his general education at Huddersfield and at Owens College, Manchester. His professional studies were carried on in Manchester and partly in Paris, and later at St. Mary's Hospital, London. He became M.B. of the University of London in 1858, and M.D. of the same University in 1860, and a member of the College of Physicians in the year following. At a later date the latter body elected him a Fellow, and on two occasions appointed him to the important office of Censor. One of his first appointments in London was in connection with the Western General Dispensary, but it was not long before he was appointed to the staff of his own hospital, St. Mary's, working in its medical school for many years as lecturer on clinical medicine.

He completed two terms of office as honorary physician and later as consulting physician. Sir William became connected with the Court at a comparatively early date. He was summoned to attend the Prince of Wales, then Prince George of Wales, when brought to Marlborough House from Sandringham, suffering from typhoid fever in 1891. He was also one of the physicians in attendance on the late Duke of Clarence in the following year. Similarly he was frequently at the bedside of Queen Victoria during her last days in 1901, and more recently took part in the treatment of King Edward during the illness which led to the postponement of his Coronation in 1902. Some three years before her death the late Queen appointed him to the position of Physician Extra-ordinary, and the King on his accession confirmed him in the office of Physician in Ordinary, which he held when the King was Prince of Wales.

Sir William Broadbent was closely connected with the professional life of London. He filled the office of President of the Harveian Society, the Clinical, the Neurological Societies, and the Medical Society of London. He was also a vice-president of the Cancer

Research Fund, and President of the British Medical Benevolent Fund, besides playing an important part in the organisation and conduct of the National Association for the Prevention of Tuberculosis. He received honorary degrees from Edinburgh, Leeds, St. Andrews, Canada and the United States, and was a Fellow of the Royal Society of England. He was also honorary member of a great number of learned societies of Berlin, Vienna, and other continental cities.

Sir William's contributions to literature were numerous and he wrote several books, some of which have gone through many editions. The best known and most popular was that upon "Heart Disease," while among others may be specially mentioned "The Pulse," and "The Mechanism of Speech and thought."

Sir William was created a baronet in 1893, and in the year of the Coronation he was created K.C.V.O. He was also made Commander of the Legion of Honour, on the occasion of the visit of a number of distinguished English medical men to Paris, some years since.

In 1863 Sir William married a daughter of Mr. John Harpin, who survives him with a family of five children. He is succeeded in the title by his eldest son, John Francis Harpin, who was born in 1865, and is in practice as a physician.

Before his death Sir William Broadbent had been away in the country for five months, having had to abandon practice during that period. In his last illness he was attended by Sir Thomas Barlow, Prof. Osler, and Mr. Edmund Owen. It was only in January last that he celebrated his seventy-second birthday.

By his death one of the foremost figures in the profession has been lost to us. His intellect was essentially that of the sane and wholesome type that confers upon the medical life of our nation its peculiar excellence. A forcible testimony to the personal worth of this great physician is afforded by the warm personal interest and friendship which the Royal Family have always shown in his career.

At the memorial service, held on Saturday last at the Church of St. Peter, the King and Queen were represented by the Hon. Sidney Greville, and the Prince and Princess of Wales by Sir James Reid. Practically all the medical institutions and societies in London were represented, the coffin was covered with wreaths, one being from the Queen, inscribed, "In grateful remembrance, from Alexandra." The funeral afterwards took place at Wendover Churchyard, Buckinghamshire.

SPECIAL REPORTS.

ROYAL COLLEGE OF SURGEONS— ELECTION OF PRESIDENT.

A quarterly meeting of the council of the College took place last Thursday, Mr. Mansell Moullin, Mr Frederick Eve, Mr. Bruce Clarke, and Mr. C. J. Symonds the successful candidates at the recent election of Fellows to the Council, were introduced and took their seats as members of the Council.

Mr. Henry Morris was re-elected president, and Mr. Rickman J. Godlee and Mr. Watson Cheyne, C.B., F.R.S., were elected vice-presidents of the college for the ensuing collegiate year. The following professors and lecturers were appointed :—Dr. Wm. S. Handley, one lecture on therapeutic criteria in cancer; Dr. Victor Bonney, three lectures on the connective tissues in carcinoma; Mr. Donald Armour, three lectures on the surgery of the spinal cord and its membranes; Mr. A. R. Thompson two lectures on the anatomy of the long bones relative to certain fractures, and Dr. F. C. Shrubsall, three lectures on the physical anthropology of the pigmy and negro races of Africa. Arris and Gale lecturers: Dr. F. A. Bainbridge, one lecture on the pathology of acid intoxication; and Mr. Major Greenwood, junr., two lectures on the physiological and pathological effects which follows exposure to compressed air. Erasmus Wilson lecturers: Mr. S. G. Shattock, one lecture on ovarian teratoma; Dr. W. H. Eyre, one lecture on the surgical importance of the pyogenetic activities of diplococcus pneumonia; and Mr. L. S. Dudgeon, one lecture on infection of the urinary tract due to bacillus coli.

The president reported that by the death of Miss Moncrieff Arnott the legacy of £1,000 bequeathed to the college by Mr. James Moncrieff Arnott, a former president of the college, became payable to the college, and that by her will Miss Arnott had left to the college an oil painting of her father. The Museum Committee submitted the revised edition of the catalogue of the physiological series of comparative anatomy in the museum, and also submitted a revised edition of the catalogue of the osteological specimens (man).

The President reported that the vacancy on the Court of Examiners caused by the retirement of Mr. Golding-Bird, would be filled up at the next meeting of the Council on the 25th instant. Mr. Golding-Bird does not intend to seek re-appointment to the office.

A vote of thanks was presented to Sir John Tweedy for presenting Rymer's Fœdera, twenty volumes folio, published in the year 1711, to the library. The council accepted the resignation of Mr. C. R. Hewitt, assistant in the library, and expressed their thanks to him for his services to the college during the past twenty-two years. Mr Hewitt has accepted a librarianship in the Royal Society of Medicine.

In accordance with the recommendation of the committee of management of the two Royal Colleges, it was decided to add the following schools to the list of institutions recognised by the examining board in England for instruction in chemistry and physics: Aldenham School, Elstree, and the Municipal Technical School, Birmingham.

ROYAL COLLEGE OF SURGEONS, IRELAND.— ROYAL VISIT.

On the occasion of the recent Royal visit, the following Address was presented by the College:—

"To His Most Gracious Majesty, Edward VII., King of Great Britain and Ireland and all the Dominions beyond the Seas, Emperor of India; and to Her Most Gracious Majesty, Queen Alexandra. May it please your Majesties,—We, the President, Vice-President, and Council of the Royal College of Surgeons in Ireland, desire to avail ourselves of the presence of your Majesties in Dublin to offer the assurance of our allegiance to your Majesties and our respectful and loyal welcome on the occasion of your gracious visit to Ireland. It is the object of our Royal College to provide highly qualified surgeons who may serve their country in the naval or military services, as well as those others who will devote their lives to the care of the sick in the civil community. Knowing the deep interest your Majesties take in all that concerns the welfare of your subjects and the progress of surgical science, we feel confident that our Royal College may rely on your Majesties' favour in our continued efforts to secure the efficiency of those who seek diplomas.—Signed, on behalf of the Council, Henry R. Swanzy, (President), John Lentaigne (Vice-President), Charles A. Cameron (Secretary). July 11th, 1907."

His Majesty's General Reply.

A copy of his Majesty's general reply was handed to each deputation, and at the conclusion of the presentation of addresses, the King said:—

"Gentlemen,—I thank you for the hearty greetings and cordial welcome which you have tendered to the Queen and to myself, and I accept with sincere gratification your loyal assurances of devotion to my Throne and person. I am pleased to hear of your success in your various spheres of public duty, and I trust that a blessing may continually follow your labours for the prosperity of the country and the welfare of the people. I regret that time does not admit of an individual acknowledgment of your addresses, but I ask you to accept from the Queen and from myself an assurance of our gratification at your kindly reception of us and of our hearty sympathy with you in your efforts for the good of the various communities which you represent."

LABORATORY REPORTS.

PLASMON BISCUITS.

Many articles of food can now be obtained in which the amount of protein has been increased by the incorporation of that valuable proteid, Plasmon. These preparations can be confidently relied on where it is desired to administer protein matter in an easily assimilable form. There are now nine varieties of Plasmon biscuits—plain, sweet, wholemeal, rusks, ginger nuts, fancy, oat, wafer, and cracker, and in these biscuits there is considerably more protein matter than in ordinary kinds. Long experience of Plasmon preparations has caused us to expect a very high standard of excellence from foods bearing this name, and our expectations are not disappointed. So far as these biscuits are concerned, it is evident that careful attention has been paid to the details of their composition and manufacture, with the result that not only are their nutritive values high, but their appearance and flavour will commend themselves to patients.

We have submitted the plain biscuit and the rusk to a chemical examination, and we find the former to contain 20·83 per cent. of proteins, 2·94 per cent. of ash, and 6·38 per cent. of moisture. Plasmon rusks contain 16·27 per cent. of proteins, 6·18 per cent. of moisture, and 1·56 per cent. of mineral matter. The flavouring of this biscuit is excellent. The ratio of albuminoids to carbon-hydrates is, therefore, satisfactorily high. The sole manufacturing rights for Plasmon biscuits have been secured by Messrs. Mackenzie and Mackenzie, of Edinburgh, who have made special arrangements to conserve the full qualities of the Plasmon proportion. Our analyses show that Messrs. Mackenzie and Mackenzie are keeping these preparations up to a high level.

ARMOUR'S EXTRACT OF RED MARROW.

The value of red marrow in certain forms of anæmia has become one of the established facts of modern therapeutics. It is therefore of advantage to medical practitioners to have a trustworthy preparation on the market. An excellent product of the kind is the glycerine extract of red marrow, a bottle of which has just reached us from the well-known laboratories of Armour and Co., Ltd., of London. It is guaranteed to be made from carefully selected fresh material, and to contain all the essential ingredients of red marrow. We have pleasure in drawing the attention of our readers to this elegant and valuable preparation as a remedy in chlorosis and various forms of anæmia and perverted nutrition.

REVIEWS OF BOOKS.

DISEASES OF THE NOSE AND PHARYNX. (a)

This excellent handbook has now reached its fifth edition, a fact which speaks for itself. The plan of the book is very good. It is divided into four parts. The first treats of general considerations, including anatomy, physiology, general diagnosis, and methods of treatment; the second, diseases of the nose and naso-pharynx; the third, diseases of the accessory sinuses; the fourth, diseases of the pharynx.

Written chiefly for the use of students and practitioners, it gives a clear and more or less dogmatic account of the diseases of which it treats. Though aiming at conciseness, the descriptions of the various conditions are very thorough and up-to-date. Indeed, far more so than in some much more pretentious works lately published—for instance, a very good account of the operation for submucous resection of the septum is given in Chapter XVIII., and the latest treatment of that distressing and intractable malady—hay-fever—in Chapter XIII. Some useful formulæ and a good index are added. The binding, printing, and general get-up of the book are excellent.

ANÆSTHETICS (a).

We extend a cordial welcome to the new edition of Dr. Buxton's book, not only as a sign of the increasing interest taken in the subject, but also as it has enabled the author to give us his experience and judgment of the recent advances which have taken place in the practice of anæsthetists. The use of ethyl chloride as a general anæsthetic was in its infancy when the last edition was published, and consequently the book contained a very meagre account of its uses and administration. One can hardly say that the place which this anæsthetic is permanently to assume has been settled yet, but its advantages and limitations are becoming every day more definite. We agree with our author that its field of usefulness is much more circumscribed than it was believed to be by many five years ago, but we cannot agree with him altogether in the comparison which he institutes between it and other anæsthetics. To compare ethyl chloride with ether or chloroform as to safety is, in our opinion, to endeavour to compare things which are not comparable. The conditions under which the administration takes place make all the difference. Under suitable conditions we believe ethyl chloride to be a safe and very useful drug, but one must always bear in mind that it is a most powerful and rapidly acting drug, much more so probably than either ether or chloroform, and consequently its safety will depend to a large extent on a knowledge of its limitations.

Another subject the treatment of which is quite new in this edition of the book, is the dosimetric administration of chloroform, and here Dr. Buxton speaks with the authority of an experience which is probably unrivalled among anæsthetists. Since the introduction of the Vernon-Harcourt and other regulating inhalers the chloroform controversy has assumed a new phase; the dispute is no longer between the merits of ether and chloroform, but between the methods of administration of the latter. Dr. Buxton has demonstrated that, in his hands, at all events, the new method can give excellent results. He says, "From an experience of three years and some thousands of cases, many of the gravest character, I may say, I have found the inhaler fulfils all the purposes for which it was constructed. . . . It is easy to manage, and when once learned will prove reliable and satisfactory. There have been no dangerous symptoms due to the anæsthetic in the cases in which I have used the inhaler, and no failures." This is strong testimony in support of the method, but it is an individual and not a general experience, and other workers have not been so fortunate. In our opinion this phase of the controversy will end as did the former, for it is neither the method nor the drug which constitute the safety, but the knowledge and attention of the administrator. Undoubtedly a careless administrator may be less dangerous with a regulating inhaler than with a Skinner's mask and drop bottle, but the condition is one of less danger and not safety. We believe, as is pointed out in Gill's work on the CHC_{13}-Problem, reviewed in these columns a few weeks since, and as maintained by the Hyderabad Commission, that safety in chloroform administration depends on the maintainence of the integrity of the respiration. With the regulating inhalers, unless this is maintained free, either no anæsthesia or dangerous symptoms will follow, the former most probably, hence the safety. With the drop method of administration if the respiration is kept quite free, an overdose can scarcely be given; but with any obstruction to the breathing danger is more likely to follow if this obstruction is not recognised, and at once corrected, than with the regulating apparatus. It is in the recognition of the various forms of this obstructed breathing that the skill and attention of the administrator are shown, and it is this that confers the element of safety to the administration in his hands. We should like to see more space devoted in works on anæsthetics to this subject, and believe it would be very much more useful to the beginner than elaborate dissertations on different methods. Dr. Buxton has added to this edition of his work a chapter on local anæsthetics which will make the book much more valuable and complete from the point of view of the general practitioner.

(a) "A Handbook of Diseases of the Nose and Pharynx." By James B. Ball, M.D.Lond., Physician to the Department for Diseases of the Throat, Nose, and Ear, West London Hospital, &c., &c. Fifth Edition. Pp. xii. and 388; illustrations, 78. Price 7s. 6d. net. London: Bailliere, Tindall, and Cox.

(b) "Anæsthetics: Their Uses and Administration." By Dudley W. Buxton, M.D., Administrator of Anæsthetics and Lecturer in University College Hospital. Fourth Edition. London: H. K. Lewis. 1907. 8vo, pp. viii. and 415.

SKIN DISEASES. (*a*)

Of the many dermatological text-books extant few meet the needs of the busy practitioner in dealing adequately with treatment, and being at the same time concise. Dr. Whitfield's handbook should speedily become popular in this respect, for it contains much of practical interest from the therapeutic standpoint without being too bulky. The various diseases of the skin are dealt with in twenty chapters, considerable space being devoted to eczema and its allies. The author has struck the right note here when he says, with regard to treatment, that "the first thing to do is to discover how much is due to external and how much to internal influence." He does not mention, however, the necessity for caution in the application of strong remedies for the eczema of infants, owing to the danger of absorption of such medicaments as carbolic acid, strong mercurials, &c., though the risk of inducing pneumonia from applying evaporating lotions over large surfaces is stated. The alleged danger resulting from the too rapid cure of an infantile eczema is touched upon, and infection by pyogenic organisms, among other factors, is warned against. Most will agree in the reservation of arsenic for eczema of the nails only.

In the matter of classification of skin diseases there are differences of course of opinion but we confess that we do not view with favour the inclusion of seborrhœa capitis under the heading of *pityriasis alba* among the "Diseases due to Vegetable Parasites other than Bacteria," still less do we agree with the description of true seborrhœic dermatitis as one variety of chronic eczema. In this connection may be noticed a good account of the special form of dermatitis known as *discoid eczema*, which has been made a special study of by Dr. Whitfield. The various parasitic affections receive considerable attention. We note that the author states that "there is no justification" for the use of formalin in the treatment of ringworm of the scalp, an assertion with which we are in the fullest accord. A good description is given of the X-Ray technique to be carried out in this class of case. The author is, perhaps, a little inclined to be pessimistic in treatment, in such affections as pityriasis rubra and feigned eruptions, but this is better than being too sanguine. There is a full account of the injuries which may be wrought upon the skin by the use or mis-use of the X-Rays, but we do not find any mention of radium as a therapeutic agent nor of the employment of cataphoretic medication for such conditions as rodent ulcer. Nevertheless, the book is full of good points, well got up, and illustrated by some really telling photographs taken by the author.

SANITARY ENGINEERING AND WATER SUPPLY (*b*).

This volume is the latest addition to Messrs. Longmans' famous Civil Engineering Series, and it forms a worthy addition to this collection. The preparation of the work has occupied the spare time of the author for the last five years. That these periods of leisure have been well spent is obvious, and although there is not very much that is novel or new in the book, Mr. Vernon-Harcourt has served his generation well in writing on a subject so important to the public health. As little as possible technical language has been employed, with the result that those who have hitherto been deterred from a serious study of the subject because of the technicalities, have now at their disposal a trustworthy guide to engineering as applied to water and sewage matters. In the part relating to Water Supply, the sources of supply, its purification, and distribution, are fully discussed, as also is the construction of wells, reservoirs and dams.

The second part dealing with sewage disposal contains a mass of judiciously selected information as to house drainage, the construction of sewage works, the various ways of disposing of the crude or purified sewage and other matter relating to the subject.

The illustrations are clear and well show the points they are intended to illustrate. It is a book that will be of immense service to medical officers and sanitary authorities, as well as to water and sewage engineers, and we can heartily commend it to such. The author is an eminent authority on his subject, and he fully realises the points and details on which it is necessary to lay emphasis. His wide knowledge of the subject enables him to give examples that not only form interesting reading, but are of great service in helping the reader to appreciate the point at issue, and to differentiate between the different methods. We should not be far wrong in characterising the volume as a collation of examples, judiciously interspersed with theory.

BRAIN SURGERY. (*a*)

This volume is an expansion of the author's Lettsonian Lectures for 1906. He seems to have aimed at making it a book of that valuable type that, without giving a complete text-book account of a subject, presents certain aspects from a personal standpoint, and illustrates these aspects from a special experience. It is encouraging to find that this important class of books is increasing, and tend to replace to some extent the stereotyped manuals.

Chapter I. deals from the surgical standpoint with various affections of the meninges. Our increasing knowledge of these affections is illustrated by a description of well-chosen cases, most of which had occurred in the author's own experience. Original contributions to this knowledge are inconspicuous, but the amount given forms a readable summary. We note that the author uncompromisingly advocates progressive methods, in the form of readier recourse to operative measures, in the case of the suppurative meningites. He is hopeful about the future advances that will certainly be made in this direction, and even sees ground for the belief that tuberculous meningitis may yield to similar treatment. Perhaps the most interesting part of this section is the account given of the treatment of hydrocephalus, where the author's personal experience is particularly valuable. On the matter of diagnosis he is less happy, and many of his statements are very open to question. To say, for instance (p. 61) that optic neuritis is, as a rule, a late sign in tuberculous meningitis and an early one in suppurative meningitis, is to render oneself open to misinterpretation. It is only true in so far as tuberculous meningitis is of longer duration than the other, but there is no evidence that relatively optic neuritis is an early sign in the latter, and a late one in the former. Far more important is the fact that optic neuritis is greatly (more than twenty times) more frequent in the former case than in the latter, and this is not even mentioned by the author. On page 57 is the astonishing statement that in a suspected case of typhoid fever an absent knee-jerk or early disc

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(*a*) "A Handbook of Skin Diseases and their Treatment." By Arthur Whitfield, M.D., F.R.C.P., Professor of Dermatology at King's College. Pp. xii., 320, with 50 photographs. London: Edward Arnold. 1907. 8s. 6d. net.

(*b*) "Sanitary Engineering with Respect to Water Supply and Sewage Disposal." By Leveson Francis Vernon-Harcourt, M.A., M.Inst.C.E. Emeritus Professor of Civil Engineering and Surveying, University College, London. Price 14s. net. Pp. 419 and xxi., with 287 illustrations. Medium 8vo, London: Longmans, Green and Company. 1907.

(*a*) "Some Points in the Surgery of the Brain." By Charles A. Ballance, M.S., F.R.C.S. 1907. Pp. 405. London: Macmillan and Company. 15s. net.

changes would be pathognomonic of intra-cranial inflammation. Rolleston has shown that the knee-jerk is absent in 10 per cent. of ordinary cases of typhoid fever; the presence of optic neuritis is, of course, by no means rare in typhoid fever, and is far commoner in cases free from intracranial complications, such as typhoid meningitis, than in those with such complications.

Chapter II. deals with abscess of the brain, and is, perhaps, the most valuable section in the book. A good account of the course of symptoms is given, the classic description by Brissand and Souques being closely followed. The frequency of tuberculous ear disease followed by tuberculous meningitis is insisted on, and the importance of it in diagnosis pointed out. Naturally the author is a strong advocate of the treatment of cerebral abscess according to the principles of surgery now established.

Chapter IV. deals with tumor cerebri, and comprises nearly two-thirds of the volume. A large number of cases are described in detail, many being taken from published records.

It is unfortunate that the author suffers, like many other medical writers, from a lack of interest in English composition, for the smoothness of reading is greatly marred by the results of this. The opening sentence contains a split infinitive, and the impression there created is not effaced by such sentences as that on page 20, in which the following ambiguous or libellous passage occurs: "I successfully removed such a cyst . . . from a patient of Dr. James Taylor, who had narrowly escaped being consigned to a lunatic asylum, where he might possibly have been labelled 'general paralysis,' and died without relief." There are also many verbal inaccuracies, a few of which may be cited. On page 173, "insolvable" occurs in place of "insoluble." M. Lejonne is called Lejeune on pages 319 and 375. In a reference on page 375 to the "Revue de Neurologie," it is not stated whether the *Revue Neurologique* or the *Journal de Neurologie* is meant; as a matter of fact, the reference indicated is in the former of these, but on page 846, not page 840, as stated by the author. *Archiv fur Psychiatrie und Neurologie*, on page 376, should be *Archiv fur Psychiatrie und Newenkaukheiten*. *Deutsche Zeitschrift fur Neurologie* (page 377) should be *Deutsche Zeitschrift fur Newenheilkunde*. The references given are, however, interesting historically. On page 236, the author makes the same mistake that Holmes and Stewart made in their important article on cerebellar tumours of speaking of diadocokinesis as a physical sign of disease. Diadocokinesis is a term invented by Babinski to indicate the capacity rapidly to perform successive movements; impairment of this capacity is a physical sign of disease.

The volume is profusely illustrated with excellent photographs and drawings, many of which, such as those on pages 44, 45, 288, 289, &c., are, however, totally superfluous. It does not pretend to be a systematic treatise on the subjects dealt with, and, naturally, will not be read for this purpose. Its value for any other purpose is greatly lessened by the disorderly arrangement adopted. The book would have been better had the author dealt concisely and fully with the matters on which he is specially qualified to speak, and had he checked his tendencies to range diffusely over a multitude of subjects, from Aphasia to the Evolution of Right-handedness, many of which could be dealt with only superficially and have only an indirect bearing on the questions at issue.

HUMAN PHYSIOLOGY. (a)

Professor Tigerstedt's "Lehrbuch der Physiologie des Menschens," since its first publication in 1897, has found much favour with teachers of physiology. It is but fitting that the field of its influence should be widened by an adequate presentation in English form. This has been ably provided by Dr. Murlin. It is a pleasure to be able to acknowledge the debt of gratitude due to the energy and enterprise of American translators and publishers by English-speaking students for such works as this which we are becoming accustomed to welcome almost as a matter of course from trans-Atlantic sources.

Tigerstedt's work, as Professor Lusk points out in his introduction, is a reliable picture of the scientific structure upon which modern medical practice is based. It is certainly true that good physiology is the only preventive of bad medicine. A work such as this affords that intellectual training which best fits the students to understand and rightly interpret the phenomena of both health and disease. Special attention is devoted, as might be expected, to the mechanism of circulative and nutritional processes, but there is a lack of due proportion in presentation which is disadvantageous to the student. Dr. Murlin states that his purpose has been to bring the work within the reach of the second-year medical student. Whether this object will be attained in America we cannot say, but with the numerous modern well-balanced manuals by recognised teachers now available in this country we fear Professor Tigerstedt's bulky work will have difficulty in securing anything like a position of popularity among the examiner-fearing students of British universities and colleges.

The work, however, is one which should be welcomed by all physiologists and both teachers and students should regard it as a reliable, attractive and judiciously illustrated work for general reading and reference.

(a) "A Text-book of Human Physiology." By Dr. Robert Tigerstedt, Professor of Physiology in the University of Helsingfors, Finland. Translated from the German and Edited by John R. Murlin, A.M., Ph.D., Assistant Professor Physiology in the University and Bellevue Hospital Medical College, New York. London: Sidney Appleton. 1906.

THE PHILOSOPHY AND PATHOLOGY OF WORRY. (a)

"Worry is, in general, a wholly futile and evil thing." This is the dictum of Dr. Saleeby, who writes as a philosophic medical observer, well trained in the methods of the scientist and yet with keen intuitive perception of life's perplexities and problems, as they appear to the ordinary layman. It is a misfortune that it is given to but few writers on matters medical to have the happy gift of presenting scientific truths in form and language suited to the understanding of "the man in the street." Dr. Saleeby is one of the few who possess the gift of imparting sound knowledge in a popular and acceptable manner without the sacrifice of scientific precision. He writes with a wealth of diction and grace of style which mark his works with distinction. In this, his latest volume, he deals with a malady which sooner or later overtakes us nearly all. The study is timely and in this day of stress and strain demands serious attention. It is a work which should be read by every physician and may well be considered by each burden-bearer in life's busy workshop. The nature, significance, and consequences of worry and its associations with bodily and mental disease are thoughtfully dealt with. The evil effects of dulling care by drugs and drinks is graphically portrayed. The worries of childhood and old age, the connections of worry with sex, and psychological states are dealt with in a manner helpful and suggestive. Dr. Saleeby is a bold writer and does not hesitate to express his views dogmatically. An older essayist would doubtless have qualified many of the statements relating to religious worry, and worry as a maker of religions, in regard to which Dr. Saleeby has allowed himself much freedom of thought and liberty in expression. The work throughout is planned on broad and comprehensive lines, and is imbued with a sense of responsibility, a spirit of reverence for man and his noblest manifestations and highest aspirations, and a scientifically-directed altruism which projects itself into the future. We commend the book to all worriers and worried.

(a) "Worry: The Disease of the Age." By C. W. Saleeby, M.D., F.R.S.Edin. Pp. 312. London, Paris, New York, and Melbourne: Cassell and Company, Limited. 1907. Price 6s.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Albuminuria of Adolescence. — Heywood (*The Manchester Medical Chronicle*, June, 1907) discusses the conditions under which serum albumin appears in the urine in otherwise healthy young people. With a view to discovering the frequency and character of residual albuminuria following scarlet fever, the urines of 39 children, all of whom had suffered from scarlet fever, were examined. All the children were apparently perfectly healthy, and in at least 36 of them there never had been any anasarca or symptoms of uræmia. In 21 cases, the urine was examined at some period during the first year following the freedom from isolation; in 15 cases the interval was from one to three years, and in three cases was over three years. The patients' ages varied from 3 to 18 years. In 19 of these patients, the urine was found to contain albumin which was easily demonstrable by ordinary clinical tests. It was further found that the percentage of albuminous cases was about the same for those tested during the first year and for those tested during the second and third years. Further, it was found that the early and late residual albuminuria did not differ much in type. Sex did not appear to have any influence, but the younger the child was when attacked by scarlet fever the less liable did he appear to be to suffer from residual albuminuria. In only one case was the albumin constantly present, and in that case it was subject to cylic variations. Various writers differ considerably as to the number of scarlet fever patients who suffer from albuminuria. The returns from the Metropolitan Asylums Board, dealing with 66,871 cases, put the percentage at 13.67, while Grainger Stewart and Thomson put it at 60 per cent. Heywood concludes that about 50 per cent. of patients attacked by scarlet fever suffer from albuminuria during the course of the disease. As regards prognosis, he believes that the vast majority of cases of albuminuria in the young recover; the minority, which include those cases in which granular and epithelial casts are found, remain unaltered or pass on to chronic granular nephritis. K.

The Prognosis in Transient Glycosuria.—Barringer and Roper (*Amer. Journ. of the Med. Sciences*, June, 1907) discuss this very important question and the relation of this condition to alimentary glycosuria. The writers define transient spontaneous glycosuria as that which occurs occasionally in patients on ordinary diet, and for which none of the various causes of glycosuria can be discovered. Von Noorden has expressed the opinion that such glycosuria is in most cases the warning signal of latent diabetic disease. In order to estimate the value of this opinion, the writers have examined 20 such patients, and find that four of them in from five to eight years have developed mild diabetes, while a considerable number of the remainder showed sugar in the urine on the ingestion of 100 grams of glucose. Of these later cases, the majority eventually became diabetic. The writers consider that "these various facts may be explained by an assumption, which readily suggests itself, that is, the division, broadly, of spontaneous glycosuria into two types: (1) A class essentially diabetic from the onset, in which sugar recurs, which shows constantly glycosuria, and which, at the end of five or more years has become diabetic or probably diabetic. (2) A class quite harmless, in which sugar does not recur after the first weeks, and which does not show a glycosuria *e saccharo* except, perhaps, during the first weeks, and does not develop diabetes. The glucose test would, therefore, seem to give important help in differentiating these two provisional types of spontaneous glycosuria at a relatively early date." Such a differentiation is of considerable importance not only for prognosis, but also for treatment, for it is of importance that the former should be kept on a restricted diet even though the glycosuria has not recurred, while the latter need not be subjected to such restriction. K.

Treatment of Diabetes by Drugs.—Parsons (*Practitioner*, July, 1907) reviews the use of drugs in this disease under the following heads: (1) To control the glycosuria; (2) to avert or remove coma; and (3) to relieve symptoms and complications. He concludes that opium is the best anti-glycosuria drug at present available, and it is most useful in the severe cases in which a rigid diet fails to remove all sugar from the urine. Sodium salicylate and aspirin in 15 grain doses three times a day are both useful in mild cases, and jambul may be used as an alternative to either of these. Sodium bicarbonate in doses from 150 grains up, is useful to avert coma, and an intravenous injection of 35 ozs. of a 3 or 4 per cent. solution of the carbonate of soda affords the best chance of restoring consciousness in diabetic coma. Constipation should be guarded against in all stages of the disease. K.

Infantile Paralysis.—Numerous attempts have been made of late years to bring about a cure of localised paralysis due to acute anterior poliomyelitis by surgical methods. The more important of these methods have consisted of tendon transplantations and of nerve grafting. Nerve grafting has been principally carried out in cases of upper-arm paralysis, and the operation has usually consisted of implanting the diseased trunk of the brachial plexus into a neighbouring healthy trunk. Babcock now reports a case in which a novel method was adopted (*Journ. of Amer. Med. Assoc.*, Vol. 48, No. 21, p. 1742), to which he applies the term of transbrachial anastomosis. The case was that of a boy, æt. 4, who suffered from very extensive paralysis of the right arm, and also of the trapezius muscle. Owing to the extent it was found impossible to perform the more usual operations, and in consequence both brachial plexuses were exposed and a bundle of healthy nerve fibres was separated from the sixth left cervical trunk and cut across. A tunnel was then bored between the anterior muscles of the neck and the trachea, and through this the bundle was brought across the neck to be sutured to the distal end of the atrophied right sixth cervical trunk. The child was seen three and a half months after the operation, and it was then found that the left arm had not suffered in any way, and that the right arm was considerably improved, the scapular muscles, the pectorals, and the extensors of the fingers showing most beneficial change. The writers discuss the way in which the improvement may have taken place, and suggest the following: (1) That the splitting of nerve trunks reduces the pressure in individual nerve fibres, thus enabling compressed fibres to again functionate. (2) That in splitting of nerve trunks many fibres must necessarily be cut. Some of these cut fibres may be normal and some degenerated; if then new anastomoses occur, function might be partially restored to paralysed parts. (3) That new fibres actually grew from the left brachial plexus into the right. This they regard as the most likely explanation of the improvement in this case. M.

Treatment of Gastric Adhesions by Fibrolysin.—As is well known, Hebra demonstrated some fifteen years ago that thiosinamine was an agent capable of softening cicatricial tissue. The drug, however, never came into extensive use, owing to its general insolubility, and owing to the pain caused by its hypodermic use. Mendel has, however, succeeded in combining a molecule of thiosinamine with half a molecule of sodium salicylate, and producing a soluble substance, to which he has given the name of fibrolysin. This drug has the same action on scar tissue as thiosinamine, and is quite painless when given intravenously or hypodermically. Herschell has employed this drug in cases of dyspepsia resulting from gastric adhesions (*Folia Therapeutica*, No. 3, 1907, p. 85). He points out that in many cases of chronic dyspepsia there is a history suggesting the previous existence of ulceration, and that sometimes even pyloric thickening can be felt. The fibrous tissue which causes such thickening and the fibrous tissue that necessarily results from the healing of ulcers may, he thinks, be the site and cause of the pain complained of, and he believes that many cases would be improved if such tissue could be softened and the strictured pylorus dilated. To enable the stricture to be dilated he has employed Zabludowsky's gastric massage, and also electricity, with the object of improving the general tone of the stomach musculature. To soften the scar tissue he has given hypodermically fibrolysin and reports some successful cases. In three cases all pain disappeared after from twelve to thirty injections. In other cases no improvement was noted. M.

Acute Œdema of the Lung in Ether Narcosis.—Stevenson reports a case of the above indicated rare condition (*South African Med. Record*, Vol. V., No. 10). The patient was a boy, æt. 16, who was being operated on for appendicitis. He was anæsthetised with ethyl chloride followed by ether. Everything went well till towards the end of the operation, which had only lasted about forty minutes. Then respiration became hurried and difficult, and general cyanosis appeared. The diaphragm continued to contract and relax actively, while almost all movement of the thoracic muscles ceased. Auscultation at the same time demonstrated the presence of crepitations all over the lungs. Strychnine was injected, and warm applications applied to the chest, and after an hour of continued artificial respiration, improvement began, and recovery finally took place. The writer believes that the condition is due to vaso-motor spasm of the pulmonary arterioles, which embarrasses the right heart, and leads to the œdema. About ten cases have been recorded, and nine of these have died. The writer believes that the best treatment consists in the exhibition of nitro-glycerine or anyl nitrite. M.

Emotional Epilepsy.—Bratz and Leubuscher (*Deut. Med. Woch. Berlin and Leipzig*, 1907) have had occasion to observe for years twenty patients with what they call "Affekteplepsie," for which they claim a place apart. The patients have occasional attacks, suggesting *petit mal*, but with characteristics of hysteria. These attacks develop under the influence of long-continued emotional stress, and occur at times from early childhood onwards. The persons affected are always those with a neuropathic inheritance, and they are distinguished by a peculiar pallor, evidently a vaso-motor phenomenon. Like alcohol epilepsy, it never develops into genuine epilepsy. D.

Sodium Phosphate in Neurasthenic Conditions and in Exophthalmic Goitre.—Vetlesen (*Norsk. Mag. for Laeg.*, Christiana) has been proclaiming for some years the advantages of sodium phosphate in exophthalmic goitre. His later experience fully confirms his first assertions in regard to the efficacy of this remedy, which, he says, was first suggested by the success of organotherapy. He has now a record of 40 cases of exophthalmic goitre in which it has been applied. He tries it in every case, and generally derives great benefit from it. His present article relates his experience with it in neurasthenic conditions. He gives the details of 6 out of 30 cases in which he has administered it in his private practice, while it has been given to hundreds at the hospital. No by-effects were observed, but the tonic action on the nervous system was striking in many instances. He adds that the drug is a welcome addition to the usual measures at our command in treating the protean manifestations of neurasthenia. The examples he gives show marked benefit under sodium phosphate administration and its harmlessness even when continued for months. He orders one tablespoonful four times a day of a solution of 15 parts sodium phosphate in 250 parts water. D.

The Blood in Rheumatoid Arthritis.—Bullmore and Waterhouse (*Edinburgh Medical Journal*, June, 1907) have summarised the results of their observations on the blood in rheumatoid arthritis. Anæmia is almost always present in rheumatoid arthritis. There is, as rule, a slight diminution (to between 75 and 95 per cent.) in the number of the red blood corpuscles, and a slightly greater (70 to 90 per cent.) diminution in the amount of hæmoglobin. In the great majority of cases, the leucocytes are not increased in number, and the normal proportions of the different varieties to one another are preserved. Myelocytes in small numbers are present in a few cases only. D.

Lactic Acid Bacilli to Combat Intestinal Fermentation.—Dunn (*Archives of Pedriatics*, New York, April, 1907) pasteurized buttermilk, then inoculated it with a pure culture of lactic acid bacilli, allowing the mixture to ripen until the development of the organism had brought about the proper acidity and precipitation of the casein. In the majority of the cases the buttermilk was given only after all ordinary and routine measures had failed. Of 35 selected cases, there was evidence of a favourable result in 23; in 3, there was immediate cessation of diarrhœa and favourable change in the character of the dejecta, without gaining weight; in 9, no effect was produced. In 14 resistant cases of the fermentative type, the buttermilk was first given in the pasteurized form, and after a sufficient trial had demonstrated a failure to improve, the pasteurization was omitted. Immediate improvement followed in each case. In 4 cases of acute diarrhœa the only treatment was the administration of unpasteurized butter-milk. No castor oil or calomel, no bismuth or irrigations, and no period of starvation were employed. Two of these cases were successful; one patient improved slightly, and one case was a failure. Dunn says that the only conclusion that may safely be drawn from this study is that the use of living lactic acid bacilli is a harmless method of treatment, and that it may do good in cases of intestinal fermentation. He promises to investigate further and report later. D.

Derbyshire Royal Infirmary—New Medical Appointments.

At a special meeting of the governors of the Derbyshire Royal Infirmary held a few days since, Mr. R. Knowles, the president, in the chair, the Weekly Board recommended a number of alterations of rules, the most important being the appointment of an honorary pathologist. For some years past the policy of the governors had been to specialise the different departments of the institution. That was being done in other institutions throughout the country, and it was unquestionably the proper policy to pursue. The Board thought the time had arrived when they should bring this work under the supervision of one gentleman, who would attend to both the medical and surgical sides. They also suggested the appointment of a pathologist as a saving of time and money. Other proposed alterations had to do with the medical staff in regard to the restriction of voting, &c., the idea being to divide them into seniors and juniors, who should serve on the Elective Committee for appointment of paid medical officers, but in other appointments only the senior section should act. Sir Arthur Heywood, in expressing his approval of the policy of the Board said they were only copying the practice of the best hospitals in the country. The motion was carried.

MEDICAL NEWS IN BRIEF.

The King's Visit to Ireland.

DURING the past week their Majesties paid a brief visit to Ireland for the purpose of seeing the International Exhibition which is now in full swing. Although the time at his Majesty's disposal was so limited, he was graciously pleased to accept addresses from many public bodies, amongst whom were the Royal College of Physicians, the Royal College of Surgeons, and the Apothecaries' Hall. The address presented by the last-named body was as follows:—

"To His Most Excellent Majesty Edward VII. of Great Britain and Ireland, and the British Dominions beyond the Seas, King, Defender of the Faith, and Emperor of India, and His Most Gracious Consort Queen Alexandra,—May it please your Majesties, We the Governor, Deputy Governor, and Court of the Apothecaries' Hall of Ireland, representing a large and important branch of the Medical Profession, and one of the oldest qualifying bodies in this country, respectfully render to your Majesties our loyal and hearty greeting and welcome on your visit to our shores. May God Who has so abundantly blessed your reign, and given us in you a bright example of all that is good and benevolent, vouchsafe to your Majesties His best gifts, and His continuing protection. We bid your Majesties a most grateful welcome, and we fervently pray that your visit may be a happy one, and leave nothing but most pleasant memories.—We are your Majesties most humble, dutiful and faithful subjects, F. G. ADYE-CURRAN, Lieut.-Col. F.R.C.S., J.P., Governor; GEORGE SEYMOUR STRITCH, L.R.C.P. & S., J.P., Deputy-Governor; H.W. MASON, L.R.C.S.I., Secretary.

Davos Sanatorium.

A SATISFACTORY report in connection with the Queen Alexandra Sanatorium at Davos Platz, was presented at the recent annual meeting of supporters, under the chairmanship of Lord Burghclere. The object aimed at is to provide a cheap sanatorium in an alpine climate for consumptive patients of small means belonging to any English-speaking nationality. The report stated that a sum of £5,264 18s. [illegible]d. was raised last year—the largest received in any one year since the start of the fund. This gratifying result was due to a special appeal made by the president, Lord Balfour of Burleigh, in Scotland, and to a bazaar held at Davos.

The chairman, in moving the adoption of the report, said at the present time the Council had in hand nearly £20,000, but they required £15,000 more before they arrived at the goal of their hopes. They had been able to commence building, and expected that the roofing would be completed during the present season. All the expenses up to this point would be paid for out of funds in hand. They aimed at having sixty beds, at making the sanatorium completely self-supporting, and at keeping the fees as low as possible, say, a guinea and a half a week, or at most 35s. They intended it to be under English management, and for English-speaking patients alone, and they had no wish that it should be a rival to the excellent sanatoria which now existed in this country, but rather to act as a help and necessary adjunct. The battles against disease and suffering were the crusades of the twentieth century, and no one had preached these holy wars more effectively, or led them with greater influence, than their Majesties the King and Queen, to whose patronage the Queen Alexandra Sanatorium owed a deep debt of gratitude.

Mr. E. C. Simmons seconded, and the report was adopted. The council were unanimously re-elected.

Royal Hospital for Incurables, Dublin.

THE annual meeting of the Royal Hospital for Incurables, Dublin, was held on Thursday, the 4th inst., at the hospital, the Chairman, Mr. William Fry, presiding. The annual report stated that there are in the hospital 213 beds, and during the year the average daily number occupied was 210, being the largest amount of relief afforded for a number of years. Eight elections were held during the year, 162 candidates applied for admission, and 47 were elected—18 suffering from consumption, 8 from cancer, 8 from paralysis and nervous diseases, 5 from heart disease, 4 from rheumatism and arthritis, the remaining four being afflicted with various other forms of incurable disease. The number of deaths (40) is the lowest on record since 1889, when the hospital was considerably smaller than at present.

The following resolutions were adopted:—(1) "That this hospital is worthy of the public support." (2) "That the best thanks of this meeting are due, and are hereby tendered, to the citizens and other supporters who have hitherto aided the good work carried on in this noble institution."

The speakers included the Chairman, Sir John Nutting, Sir Thornley Stoker, Sir J. W. Moore, Dr. Finney, Mr. L. Malone, and Alderman Lyon.

Royal College of Surgeons.—Fellowship Examination.

NOTICE is hereby given that on and after January 1st, 1910, all Examinations for the Fellowship of this College will be conducted under the Scheme of Examination now known as Grade I. No candidate after above date will, under any circumstance, be admitted to examination for the Fellowship of this College under the scheme now known as Grade II., which will then cease to be used.

University of Birmingham.—Dental Department.

THE Council of the University of Birmingham have appointed Mr. Alfred William Wellings, B.D.S.Birm., L.D.S.Edin., as Lecturer in Dental Histology and Dental Pathology in place of Mr. H. P. Pickerill, M.B., B.D.S.Birm., who has been appointed Director of the Dental Department of the University of Otago, New Zealand.

Doctor's Suicide.—Remarkable Evidence in the Heanor Case.

THE inquest on the body of the late Dr. P. S. Harris, who was found shot in his lodgings on July 1st, was held by the District Coroner. Some remarkable evidence was given by Dr. Eames, with whom the deceased had been an assistant for the past five years. Asked by the Coroner if he had noticed anything peculiar about him of late, the witness said the deceased had been addicted to drink. Witness said that the previous Tuesday the deceased had eighteen or twenty patients to see. The next day witness found he had only seen four people, and when asked for an explanation he made answer, "I went to bed." Witness told him that would not do, and that he could not stand it much longer. The same evening a telephonic message came from Codnor to attend an urgent case whilst witness was away at another case. The deceased refused to answer the telephone, and said he would not go. Witness on his return sent him his notice of dismissal, telling him to go at the end of the week, and enclosing a cheque for work done. Subsequently witness gave him permission to stay on until the 18th, telling him he would do the best he could for him to obtain another situation. Witness wrote giving him permission to stay on condition that he became a teetotaller, adding that if he continued on his present course he would soon go to the dogs. Proceeding, witness recalled one or two incidents that would seem to point to the giving way of the deceased's mind. Witness was now satisfied that the deceased was not himself during the past week. He had heard of him telling patients that he was being persecuted and poisoned. Witness went on to depose to the injuries sustained by the deceased. There was evidence, he said, of three distinct attempts having been made on the man's throat. Tremendous force must have been used.

Another witness was Mrs. Moore, the deceased's landlady. She spoke to a conversation with the deceased late on Saturday evening. Dr. Harris then asked her what the people outside the windows were talking about him for. Witness told him that nothing of the kind was taking place. Describing the finding of the body, witness stated that when she could obtain no reply, she opened the bedroom door, and saw the deceased, partially dressed, lying in a pool of blood across the bed. He had the razor (produced) in his hand, and his head was nearly severed. She raised an alarm, and assistance promptly arrived.

Was he in the habit of taking more than was good for him ?—Sometimes.

During the past fortnight ?—He took middling, but I've never seen him drunk.

Had he seemed strange in his manner lately ?—I've noticed bits of things about him. Once he told me he had had a letter from his brother in Canada, and that it had upset him.

Did he ever threaten to do away with himself ?—No.

By the Foreman : Deceased lay on the bed wearing his trousers, shirt, and socks. He had pushed the bedclothes on one side, and had turned up both shirt sleeves.

Dr. Eames : You told me yesterday you had a terrible job with him the night before.

Witness : He said there was someone talking about him outside ; he said there was a scandal, and he would have a stop put to it.

By the Coroner : There was not a better conducted gentleman anywhere, and a nicer man in the house could not be wished.

The coroner having summed up, the jury found that the deceased committed "Suicide whilst of unsound mind."

PASS LISTS.

Royal College of Surgeons in Ireland.—Summer Session, 1907.

Barker Anatomical Prize.—£31 10s., G. S. Levis.

Carmichael Scholarship.—£15, J. Menton.

Gold Medals in Operative Surgery.—P. G. M. Elvery and T. Sheeley (equal).

Stoney Memorial Gold Medal in Anatomy.—Miss I. M. Clarke and G. C. Sneyd (equal).

Practical Histology.—F. W. Warren, First Prize (£2) and Medal ; J. S. Pegum, Second Prize (£1) and Certificate.

Practical Chemistry.—H. C. Gilmore and J. Kirker (equal), First Prize (£2) and Medal.

Public Health and Forensic Medicine.—H. Hunt, First Prize (£2) and Medal ; Miss C. F. Williamson, Second Prize (£1) and Certificate.

Materia Medica.—J. Menton, First Prize (£2) and Medal ; Miss C. F. Williamson, Second Prize (£1) and Certificate.

Biology.—J. T. Duncan, First Prize (£2) and Medal ; P. V. Crowe, Second Prize (£1) and Certificate.

The lectures and practical courses of the Winter Session will commence on Tuesday, October 15th.

Royal University of Ireland.

The following candidates have passed the undermentioned examinations :—

The First Examination in Medicine.—Christopher Barragry, Daniel J. Barrett, John L. Brown, Peter A. Clearkin, Maurice J. Cogan, Ernest J. Colgan, Patrick J. Corcoran, John F. Craig, Thomas P. Davy, Joseph C. Denvir, Bernard Doyle, B.A., Gerald Fitzgerald, Thomas F. S. Fulton, Michael J. Gallagher, Joseph Gorman, M.A., Thomas D. Graham, Gerald S. Harvey, James Hill, Joseph O. Hodnett, Norman L. Joynt, Francis J. Keane, James J. Keirans, John L. Kilbride, James Laverty, Hugh T. S. McClintock, Robert J. McConnell, Laurence J. J. McGrath, Michael McGuire, Aloysius D. MacMahon, Robert C. McMillan, Daniel McSparron, Cornelius Martin, William Megaw, William M. Millar, Alexander G. Mitchell, John J. H. Mitchell, Henry H. Mulholland, Henry J. V. Mullone, Daniel O'Brien, John P. O'Brien, James O'Connor, Thomas F. O'Donoghue, William M. O'Farrell, Joseph A. O'Flynn, Patrick J. O'Grady, Oriel J. O. O'Hanlon, Hugh O'Neill, Joseph Patrick, Joseph Porter, Joseph H. Porter, James M. Rushworth, Walter N. Rushworth, Maurice J. Roche, John M. Rowe, Hugh A. Skillin, Thomas Smyth, Francis J. D. Twigg, William Wilson.

The following candidates may present themselves for further examination for honours. Those qualified in two or more subjects may present themselves in all :—

Daniel J. Barrett, Ernest J. Colgan, Thomas P. Davy, Joseph C. Denver, Bernard Doyle, B.A., Gerald Fitzgerald, Gerald S. Harvey, Joseph O. Hodnett, Norman L. Joynt, Francis J. Keane, James J. Keirans, Robert J. McConnell, Michael McGuire, Aloysius D. MacMahon, Daniel McSparron, William McGaw, William M. Millar, John J. H. Mitchell, Henry J. V. Mullone, Hugh O'Neill, Joseph Patrick, Joseph H. Porter, James M. Rushworth, Hugh A. Skillen, Thomas Smyth, William Wilson.

Trinity College, Dublin.

The following passed the Intermediate Medical Examination during Trinity Term, 1907 :—

Part I.—Adrian Stokes and Charles M. Finny, passed on High Marks.

The following names are arranged in order of merit : Marius A. Diemont, Hilgard Müller, Roclif A. Albertyn, Vicars M. Fisher, Beatrice M. Hamilton, Perceval G. Leeman, Victor G. Best, David Duff (Sch.), John H. Woodroffe, Edmund F. Lawson (Sch.), John G. Ronaldson, Arthur C. Hallowes, Benjamin A. Molyneux, Louis Trichard, John G. Dods, Edward P. Allman-Smith, Edwin B. Bate, Brinsley H. Moore, Charles Pentland.

Part II.—Albert J. Stals (passed on High Marks), John D. Kernan, Cecil P. Smyly, David Duff (Sch.), Benjamin A. Molyneux, Edwin B. Bate, Alexander K. Cosgrave, Louis Trichard, Hugh S. Metcalfe, William A. Nicholson.

Preliminary Science Examination.—Physics and Chemistry.—Bernard G. Quinlan, Ronald G. M'Entire, Henry L. W. Woodroffe, Patrick Murphy, James M. Elliott, Thomas G. Harpur, Arthur Chance, Edgar Ll. F. Nash, Thomas L. Bookey, Francis C. Crosslé, Arthur F. Shaw, Leonard Shiel, Osward C. Tandy, Edward H. H. Lloyd-Dodd, Francis Breen, Albert E. Malone, George M. Maybury, Robert W. Murphy, Hugh E. Williams, Hugh M'C. Fleming, Matthew M'Knight, James C. Kelly, Andreas A. Louw, Robert C. M'Kelly, Humphry L. Blackley.

Botany and Zoology.—Henry L. W. Woodroffe, Arthur F. Shaw, Francis C. Crosslé, Thomas G. Harpur, Georgina Revington, Hubert T. Bates, Eileen M. Hewitt, Frederick B. M'Carter, Gerald G. P. Beckett. (The former passed on High Marks.) Dorothy K. Milne, Francis Usher, Percy D. Long, Robert W. Murphy, John T. Higgins, Thomas King-Edwards, Henry S. Champion, Arthur Chance, Marjory Chapman, Francis T. G. Corscadden, Richard Grandy, Richard P. Pollard, James N. G. Nolan, Cecil Rutherford, Brian D. Crichton, Bernard G. Quinlan, Robert G. Ball.

The following candidates passed the Final Medical Examination, Part I. :—

*Johannes C. Pretorius, *John A. W. Ponton, *Richard P. Hadden, Henry H. Ormsby, Charles W. Laird, Albert, E. Wynne, William E. Hopkins, Samuel F. Charles, Frank Smartt, David G. Madill, Albert V. J. Richardson, James F. Clarke, George Halpin, Herbert V. Stanley, Gerald G. Mecredy, Dixie P, Clement, Arthur H. Laird, George B. M'Hutchison, Ernest C. Lambkin, Alexander S. M. Winder, James P. S. Dunn, Norman P. Jewell, William H. M'Carthy. (* Passed on High Marks.)

The Medical Travelling Prize was awarded to Robert E. Wright.

The Medical Scholarships in Anatomy and Institutes of Medicine to Adams A. M'Connel (Trinity) and Thomas A. Hughes (Stewart).

Prizes in Physics, chemistry, Botany, and Zoology to Henry J. Smyly (Trinity) and Herbert de L. Crawford (Stewart).

The Purser Medal in Institutes of Medicine to Charles M. Finny.

Previous Dental Examination : Anatomy and Institutes of Medicine.—George Elliott.

Physics and Chemistry.—Arthur A. Campbell and Kenneth C. MacNaught.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.**

SUBSCRIPTIONS.

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Small announcements of Practices, Assistancies. Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

M.R.C.S.—The question of a doctor's degree for the London student is a very old one, and as long ago as 1885, at a meeting of Fellows of the Royal College of Physicians of London, a resolution was passed by a large majority stating that it was desirable that students examined by the Royal College of Physicians of London and the Royal College of Surgeons of England conjointly, and found duly qualified, should, in virtue of such examination, have a degree in medicine or surgery conferred on them.

G. P. (Norwich).—All we can say is that as yet no one knows. A locum—provided his emoluments (i.e., salary, board and lodging) do not amount to £5 a week—would most probably be considered a workman, and the principal consequently liable for accident, although the engagement was a temporary one. As compensation can be obtained for so small a sum, it is certainly wise to insure with a sound office. But we agree it is hard lines. Unfortunately, ignorance of law is no excuse.

Omicron.—We cannot bring ourselves to believe that the facts are as stated, and certainly could not take the responsibility of advising on them unless very good evidence of the occurrence were forthcoming. The hospital has a high name and the staff consists of gentlemen of reputation, so we should advise you to verify the patient's statement very carefully before committing yourself. If anything further comes to light, we should be glad to hear.

A Layman.—Your communication came to hand as we were "at press"—too late to be dealt with in present issue.

Meetings of the Societies, Lectures, &c.

Wednesday, July 17th

Medical Graduates' College and Polyclinic (22 Chenies W.C.).—4 p.m.: Mr. J. Berry: Clinique. (Surgical.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Outpatient (Dr. Whipham).

Thursday, July 18th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

Hospital for Sick Children (Great Ormond Street, W.C.)—4 p.m.: Lecture:—Mr. Lane: Fractures.

Friday, July 19th.

Society for the Study of Disease in Children (11 Chandos Street, Cavendish Square, W.).—5 p.m.: Annual General Meeting.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

Bradford Poor Law Union.—Resident Assistant Medical Officer. Salary, £100 per annum, with rations, apartments, and washing. Applications to George M. Crowther, Clerk to the Guardians, Union Offices, Manor Row, Bradford.

Cancer Hospital (Free).—Two Assistant Anæsthetists. Applications to Fred, W. Howell, Sec. (See advt.)

Liverpool Infirmary for Children.—House Surgeon. Salary, £100 per annum, with board and lodging. Applications to Arnold J. Cleaver, Hon. Sec., Liverpool Children's Infirmary, Myrtle Street, Liverpool.

Middlesex Hospital, W. (Cancer Department).—Medical Officer and Registrar. Salary, £100 per annum, with board and residence. Applications to F. Clare Melhado, Secretary-Superintendent.

Rotherham Hospital and Dispensary.—Senior House Surgeon. Salary 110 per annum, with rooms, commons, and washing. Applications to the Secretary, H. Kelson, Masonic Buildings, High Street, Rotherham.

Royal Halifax Infirmary.—Second House Surgeon. Salary, £100 per annum, with residence, board, and washing. Applications to Oates Webster, Secretary, Royal Halifax Infirmary.

Royal Albert Hospital, Devonport.—Resident Medical Officer. Salary, £100 per annum, with apartments, board, fuel and lights, and laundry. Applications to the Chairman of the Selection Committee.

Stockport Union.—Stepping Hill Hospital.—Resident Assistant Medical Officer. Salary, £130 per annum, with furnished apartments, rations, etc. Applications to Charles F. Johnson, Clerk to the Guardians, Union Offices, Stockport.

Taunton and Somerset Hospital.—House Surgeon. Salary, £100 per annum, with board, lodging, and laundry. Applications to Reginald A. Goodman, Secretary, 3 Hammet Street, Taunton.

The Hospital for Sick Children.—House Physician, House Surgeon, Assistant Casualty Officer. Dates and particulars of Stewart Johnson, Sec. (See advt.)

West Ham Union.—Medical Superintendent of Infirmary. Salary, £700 per annum, with unfurnished house, light, and coal. Applications to Alfred Hall, Acting Clerk, Board Room, Union Road, Leytonstone, N.E.

West Bromwich District Hospital.—Senior House Surgeon. Salary, £110 per annum, with board, residence and laundry. Applications to T. Foley Bache, Esq., Churchill House, West Bromwich.

Appointments.

Beatty, W. J., L.R.C.P.Edin., L.F.P.S. Glasg., by the Home Secretary H.M. Referee and Judges' Assessor under the Workmen's Compensation Act (1906) for County Court Circuit 15.

Bennett, T., M.B., B.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Knaresborough District of the county of York.

Coates, F. A., L.R.C.P.Lond., M.R.C.S., Certifying Surgeon under the Factory and Workshop Act for the Whitchurch District of the county of Hants.

Corbett, Catharine L., M.B., Ch.B.Vict., Junior Assistant Medical Officer at West Ham Union Infirmary.

Fawcett, W. H., M.D.Brux., M.R.C.P., F.R.C.S.Edin., D.P.H.Lond., Assistant Physician to the Royal Victoria Hospital, Bournemouth.

Good, Arnold Saxty, L.R.C.P.Lond., M.R.C.S., District Medical Officer by the Torrington (Devon) Board of Guardians.

Goodwyn, Henry, L.R.C.P. and S., L.M.Edin., Medical Officer for the Bovey Tracey District by the Newton Abbot (Devon) Board of Guardians.

Hayes, H. W. McCaully, M.R.C.P.Edin., L.R.C.S.Edin., L.F.P.S.Glasg., Chief Medical Officer of the South Indian Railway, India.

Johnson, J., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Blackpool District of the county of Lancaster.

Mitchell, E. J. D., M.A., M.B., B.C., has been appointed Casualty Officer at St. John's Hospital for Diseases of the Skin, Leicester Square.

Morgan, James Arthur, L.R.C.P.Lond., M.R.C.S., L.S.A., Medical Officer of Health for the Llanwrtyd (Breconshire) Urban District.

Nelson, W. E., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Henley-in-Arden District of the county of Warwick.

Richards, Thomas Edward, M.B., C.M.Edin., Medical Officer and Public Vaccinator for the Ystradgynlais District by the Ystradgynlais (Breconshire) Board of Guardians.

Births.

Keeling.—On July 12th, at Market Bosworth, Nuneaton, the wife of Hugh N. Keeling, M.R.C.S., L.R.C.P., of a daughter.

Loudon.—On July 5th, at Linwood, Hamilton, Lanarkshire, the wife of J. Livingstone Loudon, M.D., D.P.H., of a son.

Newnham.—On July 10th, at 3, Lansdown Place, Victoria Square, Clifton, the wife of W. H. C. Newnham, M.A., M.B., M.R.C.S., of a daughter.

Worthington.—On July 10th, at Hurst House, Chesterfield, the wife of Sidney Worthington, M.D., of a daughter.

Marriages.

Bentham—Hall.—On July 9th, at the Parish Church, Weddington, Selina Points (Lina), youngest daughter of the late Rev. Bracebridge Hall, to the Rev. Walter Reid Bentham, youngest son of S. Bentham, M.R.C.S., L.S.A., of Hampstead.

Brownlie—Walker.—On July 11th, at the Parish Church, Saltburn-by-the-Sea, Alexander Brownlie, M.D., of Redcar, to Mabel, youngest daughter of William Walker, of Saltburn, Yorkshire.

Glanville—Bell.—On July 11th, at Hampstead Parish Church, William M. G. Glanville, M.B., B.Ch.Oxon., of Hampstead, to Muriel, eldest daughter of Edward Bell, of Hampstead.

Patmore—Scott.—On July 13th, at St. James's Church, Piccadilly, London, John Deighton, son of Dr. T. D. Patmore, to Ethel Elizabeth, daughter of James H. Scott, of Kenwyn, Leigham Court Road, Streatham.

Payne—Wise.—On July 9th, at St. Chad's, Shrewsbury, Otto Vaughan Payne, M.B., B.C., of Northwood, Alton, Hants, second son of the late W. G. Payne, F.R.C.S., to Eleanor Beatrice, younger daughter of the late D. R. Wise, of Murivance, Shrewsbury.

Deaths.

Bentham.—On July 10th, at Manchester, suddenly, of cerebral hæmorrhage, Samuel Bentham, M.R.C.S., L.S.A., of The Limes, S. Hampstead, aged 84 years.

Osgood.—On July 10th, at 165, Woodstock Road, Oxford, Hamilton Osgood, M.D., of Boston, U.S.A., in his 69th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

The Other Side of the Lantern.

AT Liverpool quite recently was held the fourth annual meeting of the British University Students' Congress, at which the dumb animal that is accustomed to being led to the slaughter of examination found both voice and audience. In the report furnished us we do not find how many students were present or were represented, but from an appended account of an Athletic Gymkhana which followed the more serious proceedings, we gather that a great many of the students were of the fair sex. The latter entertainment seems to have been a blithesome affair, the names of ladies and gentlemen being bracketed together in any number of events, but no doubt this light-heartedness was due to the elation of having in the morning disposed by unanimous resolution of some of the great problems of medical education which cause their pastors and masters so much heart-burning. But whether strictly representative or not, and even if one sex were present in undue proportion, it cannot but be interesting and instructive to hear what is thought in student-circles with regard to the course their examinations should pursue. The motion that will have most interest for medical men is one proposed by Mr. E. Darwin Wilmot, of Edinburgh, to the effect that the present lack of uniformity in medical examinations in the British Universities is detrimental to the progress of medical education; that it is desirable to establish uniformity, both in the grouping of subjects for examination and in the standard of knowledge required; and also that a State Examining Board should be appointed to control examinations.

Medical Socialism and Medical Imperialism.

THE object of this proposal, according to the supporters, was to get rid of anomalies in teaching, and also to allow students to pass freely from one University to another at any point in their career when they wished to avail themselves of any specially coveted teaching. Mr. Wilmot stated that the system of examination by the State is working satisfactorily on the Continent, and he wanted all the Colonial universities also standardised, till they came into conformity with English universities; indeed, "he would like to see the whole Empire united in one big medical school." Now although State examination is the natural corollary of State registration of medical practitioners, and the "one-portal" system is the ideal, the curious combination of medical socialism and medical imperialism suggested by this resolution—which was passed by the Students' Congress—seems to have the defects of both its qualities. If there is one good feature about university training it is that it turns out men of a certain stamp, and the competition to turn out those of the best and most successful stamp is highly advantageous. On the other hand, though it is doubtless a good thing for the young Britisher to know something of the Colonies, it is hardly likely that the bonds with the Mother Country would be cemented by turning the Empire into one vast medical school. Moreover, though it is a capital training for him to exercise his originality, the general experience of older people is that the student is eminently improved by a little healthy discipline, and if he could migrate swallow-like from one university to another as the fit took him, the salutary rigour of control would be in danger of becoming emasculated. If a student goes to a good medical school or university and partakes of its *esprit de corps*, he is likely to be better prepared for the battle of life than by leading a nomad existence in places he found pleasant.

Medical Referees and the Home Office.

Now that the Home Secretary has published the full rules and orders for the working of the Workmen's Compensation Act, 1906, as affecting the medical aspects of the points that arise under it, we are glad to be able to say that these regulations are less unfavourable than we understood them likely to be. With regard to fees to medical referees, it certainly is a sign of grace to be noted and to be thankful for that the fees for consultation have been fixed at what may be termed market-rates, that is to say, two guineas for a referee's opinion in an ordinary case, and a guinea for any supplementary report with regard to the same accident. For this sum the referee must be prepared to go any distance within two miles of his house, and for further distances he is to be given certain allowances which do not err in the direction of generosity, namely, five shillings a mile beyond two and up to ten, and a shilling a mile beyond ten. As, however, a county court district or sub-district is not a very large area, we imagine that hardship under these regulations is not very probable. The bad feature, as we conceive it, is that in the usual way the registrar of the County Court is to be the authority to decide whether a referee should be employed. Difficult situations of many kinds are likely to arise in connection with placing patronage of this kind in the hands of minor officials, and we see many elements of trouble in the arrangement. Moreover, red-tape checks and hindrances of many kinds are provided to waste time, multiply clerical work, and provoke tempers.

The Official Mind. The official mind is a curious example of how the maximum of training can produce the height of ineptitude, and it certainly is one of the blessings of the British constitution that it puts the civil service directly under Parliament, and therefore more or less in touch with the nation. The object to aim at in working a Compensation Act involving a large number of small claims should be two, namely, that the genuinely-injured workman should get his money with the least possible trouble and, secondly, that the malingerer should speedily find it was no good trying to get any at all. The more obstructive the machinery for carrying out the act, the more trouble and expense will the genuine workman have—expense which will speedily obliterate the few pounds he may be entitled to—and the more chance will rogues have of getting a week or two's wages to which they are not entitled. In the vast bulk of cases under the new Act the sole questions will be the medical ones: Is the workman disabled? And how long is he disabled for? An authoritative referee who was readily available could decide the points quickly enough in most instances, but, as it is, the registrar is only likely, in view of the fee payable, to refer to him after much delay, during which the honest will suffer and the wicked triumph. We shall be glad to hear how the new administration pans out in different parts of the country; the working of the last two acts was admittedly a clumsy failure.

Whooping-Cough Parties. *Ex America semper aliquid novi.* The extravagances of wealth have nowhere been so ostentatious as in America, a country in which mountainous fortunes and sportive imagination are wont to riot. The smaller fry take their tone from the wealthier classes and frequently ape their oddities while they do not possess their wealth. The "freak" dinners that were lately the rage in the more vulgar coterie of millionaires have, it is reported, their counterpart at Pittsburg in what may be termed pathological parties. It seems that in that city of steel an epidemic of whooping-cough is about at the moment, and as the sufferers are able to go about, and yet are tabooed by their friends, a certain lady who with her son is suffering from the disease, gave a "whooping-cough *fete*" lately to her fellow-patients. By way of entertainment, a competition was organised for those who whooped the loudest and the longest, and similarly, consolation prizes were offered for those who had the feeblest paroxysms. We should hope that the better public opinion in America would join with us in reprobating so disgusting an outrage on good taste.

On July 12th, at a meeting of the Central District Committee of Stirlingshire County Council, the Medical Officer made a statement with reference to the serious epidemic of enteric fever in the villages of Plean and Cowie. There had up to the present been seventy-six cases and seven deaths, and in his opinion the outbreak was due to infected milk from a farm. The frequent rains of the past few weeks had had a salutary effect by laying the dust between the rows of houses and keeping down flies in the houses and ashpits. The fever was now abating.

LEADING ARTICLES.

HOSPITAL FUNDS AND LOCAL HOSPITAL PRACTICE.

The question of the allocation and conditions of tenure of hospital appointments is clearly one of vital importance to the medical profession. If lay bodies assert their right to control and regulate the terms of medical staff appointments it seems a self-evident proposition that they should make sure of their ground before proceeding to take any active steps in the matter. The hospital funds occupy the position of trustees in charge of a distributing agency, but to that function they have added other claims of a remarkable nature as regards hospital administration. While few persons would question the desirability of having some sort of responsible control of the financial and administrative management of medical charity, it is, nevertheless, an entirely different thing when a Fund threatens the existence of a given hospital by denying a grant upon grounds that are arbitrary and unascertainable. The policy of the Sunday and the King Edward VII. Funds is in the hands of a group of non-representative men who have their own peculiar views upon the way sums of money should be granted and of what should be the professional status and qualifications of members of medical staffs. Take the question of amalgamation of hospitals. Three orthopædic hospitals, as we have previously insisted, were forced to amalgamate in spite of the disadvantageous sale of one enormously valuable site in Oxford Street. The Funds have permitted the charter of the amalgamated institutions to exclude Scotch and Irish diplomates from their medical staffs, in spite of the fact that two of the joining hospitals were open to gentlemen who had gained their theoretical surgical knowledge outside London. In this particular matter we hold that the Funds which urged amalgamation and did not provide against the disqualification mentioned, departed from the high standards of justice and broad-mindedness that should characterise great public bodies of the kind. We venture to say that such an indignity would not have been imposed upon Scotch and Irish diplomates had the public, the medical staffs, general practitioners and the hospitals themselves been properly represented on the management of the Funds. It is difficult to understand the frame of mind that can lead an executive of amiable philanthropists to imagine themselves gifted by a sort of divine right to control a vast number of tangled lay and professional interests. It was only at the last moment that Parliament woke up to the facts of the situation and modified the autocratic powers that were sought in the King's Fund Charter Bill. That the sphere of the Fund's activities is to be considerably extended seems clear from the action of the King Edward Fund with regard to the Hampstead Hospital. That institution afforded an admirable example of a first-rate hospital officered by local medical men. It was popular amongst its supporters, no less than amongst its patients and medical men in the neighbourhood. The King Edward Fund, however, formed a theory that the local practitioner should be replaced by consultants and that to permit this the hospital should be amalgamated with the North-West London Hospital. With regard to the amalgamation proposal from the financial aspect we have nothing to say at present, but the proposed exclusion of local practitioners from the hospital they have, so to speak, created, demands the careful attention of the whole medical profession. If the experience gained in hospital be of educational value, as it undoubtedly is, why should the Hampstead inhabitants who support the hospital consent to having that advantage taken away from their own private medical attendants ? In the provinces it is the rule rather than the exception for members of hospital staffs to engage in general practice. That plan works well enough, and we have never heard it seriously asserted that the public would gain by making consulting practice a *sine qua non* for tenure of such appointments. Why Hampstead cannot be trusted to furnish a sufficient number of local practitioners fitted to attend to its sick poor is not clear. If the King Edward Fund is to alter that state of things, which so far has worked admirably, surely the medical profession, no less than the public, are entitled to have a full and adequate explanation of why the proposal is made. It may be that the King Edward Fund has an admirable and convincing case to present, but owing to its autocratic methods, no such statement has been or is likely to be issued. Indeed, as we have pointed out on various occasions, the inherent flaw of the King Edward Fund is its want of representative control. Under its present irresponsible administration its acts and motives must necessarily from time to time be called into public question, but just as often there will be no public answer, and the reputation of the Fund will in the long run be likely to suffer. In the case of Hampstead a great deal of feeling has been imported into the dispute, and however much the motives of the Fund may be above suspicion, it can hardly be gainsaid that a feeling of resentment will linger in the minds of a great many of the inhabitants who feel that their medical attendants have been slighted, and that an attempt has been made by the Fund to hand over their institution for the benefit of another hospital and of a body of consultants hailing from another district. A further aspect of the case is the hostility likely to be aroused amongst the Hampstead practitioners by what they naturally regard as an unwarrantable attack upon their existing rights. It would require a strong body indeed to go on exciting hostility in so many classes of the community. At any rate it would be well for the King Edward Fund to lay down in black and white the principles on which its grants are to be made, and whether in the future its voice is to be equally autocratic in deciding the fate of small hospitals by the withholding of grants and the enforcing of amalgamation schemes. It is not too late, even now, for the Funds to amend their constitution and to invite to their councils representatives of the small hospitals and of the medical profession generally. It should be noted by our readers that the questions involved are of universal application and that which is taking place in London to-day may have to be encountered in any part of the United Kingdom to-morrow. It will be of some interest to watch the progress of events at Hampstead, and to note what part, if any, is taken by the Medical Defence and other professional organisations whose duty it is to safeguard the interests of the medical practitioners.

CURRENT TOPICS.

Amalgamation of the Obstetrical and Gynæcological Societies.

SINCE our last issue, containing a paragraph headed, " For London or the United Kingdom ? " we have received further and more exact information with regard to the circumstances under which the amalgamation of the Obstetrical Society and the British Gynæcological Society into a section of the Royal Society of Medicine took place. It will be remembered that we were struck with what appeared to be the disproportionate representation of some parts of the United Kingdom on the proposed Council which is to be elected in October. At first sight the figures certainly invited criticism, but we are gratified to learn that a satisfactory explanation of the disparity will be forthcoming in due time, and that an entirely different complexion will be placed on the matter than that which appears at first sight. We are not at liberty at present to treat the subject as fully as we should wish, but we hope soon to be able to deal with it at greater length. The union of these two societies under the banner of the Royal Society of Medicine is an event of such happy omen that it would be a matter of profound regret were any cloud to overshadow the new order of things.

An Englishman's Breakfast.

YOUR average Englishman is proud of many things which, deep down in his heart, he regards as distinctive of his breed. In every detail of his life he worships virility, and he looks with calm distrust upon lack of lustiness in art, science, literature, commerce, politics, sport, or religion. Good brains he can hardly dissociate from good beef and beer, not to say plum-pudding and other solid fare. Above all, breakfast is to him the test-meal of the good old insular stomach, which is always in its place when wanted, a silent, unobtrusive friend that complains not, in spite of many a buffet and a whole lifetime of ill-usage. Yet Dr. Emil Reich says that the Englishman loads his stomach at breakfast with chops and bacon and eggs and other provender that he cannot digest, and the English are therefore assumed to be rapidly degenerating in mind and body in consequence of this morning gluttony. The weak link in this Teutonic chain is the assumption that our countryman, as a rule, cannot digest a heavy breakfast. If one thing more than another constitutes the birthright of all ages of Englishmen down to the days of good King Edward VII., it is the gusto with which he disposes of a huge breakfast and the solid unconsciousness of that precedent condition which blesses the later labours of his strenuous day. The Teutonic appetite that whets itself on a species of bastard bread and a cup of coffee, to the sound of melancholy music is to the Englishman an object of contemplative and never-ceasing pity. When the English breakfast becomes a thing of the past, then, indeed, may we cry aloud because of the degeneracy of our race.

Drilling in Schools.

Signs are not wanting that the hand of sanitary science is making itself felt in the regulation of schools. For instance, one of the great achievements of modern times has been the recognition of the fact that it is no use to thrust compulsory education upon starving children. One small matter seems to have hitherto escaped the notice of school authorities, namely, the undesirability of drilling children in school-rooms. The scientific facts of the situation are clear and simple. Bacteria being heavier than air, sink sooner or later to the floor of a room. From the necessary conditions of environment a school-room becomes charged from top to bottom with multitudes of bacteria of a manifold nature. If the children have to scrape and stamp the floor in various drills and other evolutions, the bacteria will be stirred up in clouds to the detriment of all concerned. The cleaner and the better-ventilated the room, of course, the less the danger. The plain fact of the matter that stares us in the face, and should be brought no less directly to the notice of all school authorities, is that school drill should take place in the open air or in a freely-ventilated drill shed.

Mr. McKenna and School Hygiene.

We hope that Mr. McKenna who is reputed to be a capable administrator and sound Parliamentarian, is not seeking to put himself out of touch with medical opinion now that he has gone to the Education Board, nor that he is, as appears in several directions, opposed to the pushing forward of school hygiene. No doubt there is little to be got out of it politically, because all corners of the House of Commons are equally set on school hygiene being pushed forward, though unfortunately, no one is so much in earnest as to give the others no peace till universal medical inspection and regulation are accomplished facts. Still, Mr. McKenna has come fresh to a series of problems which not only have troubled men's minds for years, but about which they have long been made up, and he is displaying a feeble reluctance to lead or be led. To the *Times* last week, Sir Lauder Brunton wrote an important letter pointing out that whereas Mr. McKenna has been shielding himself from the reproach of inertia behind the International Congress on School Hygiene which is to assemble in London this summer, and while he is yet talking of all that the Education Board are doing or are going to do for it, actually all that has been done officially is to appoint three semi-official delegates, pay three guineas for their tickets, and lend two unused lecture-rooms. Now it is time to assure Mr. McKenna that medical men and we believe the whole country, have made up their minds and that they do not propose to look admiringly at the Education Board or at a politician who cares for none of these things. The religious difficulty may be insoluble; the school-hygiene problem is solved. It now only awaits masterful and energetic administration to have the whole matter speeding happily on the right track. We believe that any dallying with it will cause more unpopularity to the Government than all the religious squabbles put together.

Plague in India.

The figures quoted in the House by Mr. Secretary Morley, of the mortality from plague in India, should rouse even the most callous to a sense of the responsibility of England in the government of the dependencies. From the appearance of plague in the year 1896 to May 31st last, there were 5,402,245 deaths from that disease. During the six months ending June 30th, the number of deaths was 1,060,067, being more than had taken place during any entire year hitherto. In fact, since the first appearance of the disease, it has increased in almost steady progression year by year, the only marked exception being in 1906, when the total number of deaths was just a third of a million. The present year, however, as we have seen, threatens to be by far the worst yet. In all seriousness we say that the plague in India is the gravest problem before the country at the present time. Almost a million of our fellow-subjects are dying each year of an entirely preventable disease, and the steps taken to deal with it are of little more than a perfunctory character. Public opinion shows no interest in the subject, and hardly a daily paper has commented on the appalling figures. It is hardly matter for wonder that there is unrest in India, when disease is allowed to walk unchecked through the land. "The white man's burden" must be realised as something more than a topic for jingo songs and armchair complacency. It is a real and pressing fact which must be fairly faced. We look with anxious expectation for the full account of the policy of the Government, which Mr. Morley has promised to put before the House of Commons at an early date.

Halifax Hospital Controversy Ended.

A pithy moral may be pointed from the controversy that has been going on for some time past between the Halifax Board of Guardians and the British Medical Association. Some little while since, on the resignation of their then medical officer, the guardians advertised the vacant post at a salary of £100 per annum, or a drop of £40 on that of the last occupant. A campaign was then started by the Association, and several candidates were induced to withdraw their applications, and the Halifax vacancy was posted in a medical black list. After the failure to secure an officer at £100, the guardians advertised the post again at £120. An applicant was appointed, but the Board failed to acquaint her of the opposition of the Association, and they, moreover, induced her to sign a document agreeing to fulfil her duties under a penalty. In spite of these precautions, further negotiations went on between the local medical men and the guardians, with the result that the new officer is to start at a salary of £125. This incident proves the necessity of watchful vigilance on the part of some central body as to the terms of State, Poor Law and other public appointments. It also emphasises the value of concerted action, of publicity, and of the absolute necessity of loyalty on the part of individual members of the medical profession to the principle of collective protection and self-preservation, let journalists and guardians call it trades-unionism or what they will.

An Advance in Police-court Psychology.

The humaner administration of criminal justice is becoming by slow degrees more and more apparent as the world grows older. It will be a long time, however, before the mental responsibility or otherwise of an accused person will be submitted to any skilled and impartial arbitration. Here and there a prisoner is acquitted on the score of insanity, or of suffering from what is commonly known as kleptomania. From the account of many police cases, on the other hand, it is perfectly obvious to the medical reader that the accused must have been suffering from mania with delusions or from general paralysis. We have often urged the necessity of some central authoritative body of mental experts, to whom appeal could be made in all doubtful cases, and who should exercise a further general supervision over all trials in which the evidence suggests the desirability of special enquiry. On the Brentford bench last week, the magistrate discharged a prisoner charged with theft on the report of the police surgeon that she was suffering from minor epilepsy and that during an attack she had not the slightest knowledge of what she was doing. The magistrate enquired if that state of affairs was not very unusual, but fortunately did not adopt the usual legal attitude with regard to the plea of mental irresponsibility, namely, that of assuming an explanation which is not understandable by sane standards is, therefore, false. It is to be hoped that the Brentwood decision may be taken as an encouraging sign of the times.

PERSONAL.

The King has been pleased to appoint Sir Thomas McCall Anderson, M.D., F.F.P.S., to be one of His Majesty's Honorary Physicians in Scotland, in the room of Sir Thomas R. Fraser, M.D.Edin., LL.D.

Sir Richard Douglas Powell, K.C.V.O., has been promoted from being Physician-Extraordinary to the King to be Physician-in-Ordinary, in the place of the late Sir William Broadbent.

Dr. Bertrand Dawson, Physician to the London Hospital, has been appointed Physician-Extraordinary to the King.

Dr. A. E. Boycott, M.A., B.Sc.Oxon., has been appointed Gordon Lecturer on Pathology in the Medical School of Guy's Hospital.

The address in Medicine at the meeting of the British Medical Association will be delivered on July 31st by Dr. W. Hale White, of Guy's Hospital, who will advance "A Plea for Accuracy of Thought in Medicine."

The address in Surgery has been allotted to Mr. H. T. Butlin, of St. Bartholomew's Hospital, who will deal with "The Contagion of Cancer in Human Beings, Auto-inoculation."

A popular lecture on Weather, Climate, and Health will be given by Sir John William Moore, of Dublin.

Dr. Arnold Davies, B.A. (Lond.), a member of the Livingstone Medical Missionary College, Edinburgh, has been appointed by the London Missionary Society to succeed Dr. N. C. Bentall. in India.

In the Edinburgh Royal Maternity and Simpson Memorial Hospital last week the Committee in charge of the complimentary recognition of Sir A. R. Simpson, M.D., LL.D., met the Board of Directors, and asked their acceptance of a gift of money towards the endowment of a bed.

Dr. Henry Davy, President of the British Medical Association for 1907-8, will be inducted on the 30th inst., and will deliver his presidential address on the evening of the same day, which has been fixed for the opening of the 75th annual meeting of the Association at Exeter.

On July 13th a deputation representing the Dublin Civil Service Medical Aid Association waited upon Dr. J. J. Murphy, at his residence, to present him with an address and purse of sovereigns, as a mark of the appreciation and regard entertained by that body towards him as medical officer.

Dr. August Dupre, the well-known chemist and authority on explosives died on July 16th at his residence, Mount Edgcumbe, Surrey, in the 72nd year of his age. He had been consulting adviser to the Explosives Department of the Home Office since 1893.

Professor Chrobak, of Vienna, has resigned his appointment as Director of the Lying-in Wards and the Gynæcological Clinic in that city.

Mr. R. E. Wright has been awarded the Medical Travelling Scholarship of the University of Dublin.

Dr. H. M. Woodcock has been awarded the Royal Society's studentship in biology to help him to carry out his researches into the life-history of the hæmatozoa of birds at the Lister Institute.

Mr. G. O. Whittaker presided at the North Midland Branch of the British Dental Association's recent annual meeting.

Professor Grancher, one of the most famous of French physicians, has died at Paris.

Professor Alexander Macphail, of St. Mungo's College, Glasgow, has been appointed Lecturer on Anatomy at Charing Cross Medical School.

Professor Radner is to preside at the International Congress of Hygiene to be held at Berlin in September.

A Clinical Lecture
ON
"DISORDERS OF SLEEP." (a)

By PURVES STEWART, M.D., F.R.C.P.,

Physician to Westminster Hospital, and to the Royal Orthopaedic Hospital; Assistant-Physician to the West End Hospital for Nervous Diseases.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

Most of us spend about one-third of our life in sleep, but in spite of this, the physiology of sleep is not yet completely understood. Let us recall for a moment the chief phenomena of ordinary healthy sleep. First, there is a diminution, then a loss of conscious recognition of ordinary stimuli, stimuli which would ordinarily attract our attention, whether those stimuli be derived from the outer world, or from within our own organism. There is also the characteristic but indescribable sense of well-being with which we are all familiar, just at the moment of dropping off. Consciousness becomes blunted, voluntary movements become languid, and ultimately cease, and the muscles of the limbs relax. Meanwhile, there develops a double ptosis, respiration is slowed and becomes deeper, the pulse is slowed, the cutaneous vessels slightly dilate, and the body temperature falls a little. Many processes of metabolism, especially digestion and certain secretions, are retarded. Various explanations have been offered for these phenomena. But at the outset we should recognise that sleep is not merely a function of the brain, it implicates many organs of the body. It is generally admitted that during sleep the brain is anæmic. If we take an animal or a patient who has been trephined and observe through the trephine hole during sleep, we see that the volume of the brain is diminished, that it is pale, and that the cortical vessels are contracted. This vascular constriction is not confined to the cortical vessels, for if we succeed in examining the retina with the ophthalmoscope while the person is asleep, we find in the retinal vessels a similar constriction, so that we may conclude there is, during sleep, anæmia of the whole brain. We are all familiar with the difficulty of doing severe mental work after a heavy meal, and we know the drowsiness at such times, and the tendency to fall asleep. This is probably due to temporary abdominal hyperæmia, causing a compensatory cerebral anæmia. The activity of certain nerve cells, especially those of the cortex, is temporarily diminished. Some observers a few years ago suggested that this was due to retraction of the dendrites of the different nerve cells, whereby those cells became temporarily insulated, that there was a sort of amœboid movement of retraction. But the evidence in support of this theory is by no means convincing. In fact, modern histological observations show that the nerve cells are not anatomically independent. Other observers attribute the phenomena of sleep to poisoning of the nerve cells by the accumulation of CO_2, or to some toxic waste products of metabolism, which act as narcotics. This may be so to some extent, but it has been shown that neither CO_2 poisoning nor other intoxication are necessary to sleep. On the contrary, we usually sleep to avoid intoxication and to prevent exhaustion. Healthy sleep is not necessarily a poisoning of the nerve elements. There is a periodicity whereby the healthy person, whether he is fatigued or not, has a recurrent appetite for sleep. Sleep has a constructive, anabolic, invigorating effect on the whole body. This is, doubtless, partly due to physical rest, partly to the interruption in the production of toxines arising from muscular contractions, and partly to the absence of stimuli which, during waking hours, excite nervous katabolism.

Some writers have assigned a special importance to a particular region of the brain in connection with the function of sleep, namely, the floor of the third ventricle and the Sylvian aqueduct, pointing out, in support of this theory, the well-known ptosis and divergent strabismus, both of which might be due to a temporary paresis of the ocular nuclei. And they recall the fact that cases of tumour of that region are particularly likely to have early and persistent drowsiness. But some of these cases can be well explained in a different way; sometimes as due to cerebral anæmia. Why? A tumour at the base of the brain may mechanically compress and narrow the arteries which form the circle of Willis. This has been several times demonstrated in cases of tumours of the base and of the third ventricle. Some time ago I had under care a woman, æt. 26, with a cystic growth of the pituitary body and the floor of the third ventricle. Her only symptom was paroxysms of overpowering sleep, which increased, passed into coma and stertor, and she died. She never had any paralysis, nor optic neuritis.

Another help to natural sleep is the absence of violent external stimuli, such as loud sounds or sudden flashes of dazzling light; therefore silence and darkness conduce to sleep. A pleasing monotony of gently reiterated stimuli has a similar soothing effect, such as the sound of waves beating on the shore, or the steady red glow of a fire on a winter's afternoon, or the restful tones of the preacher's voice in church. These things cannot be ascribed to cerebral anæmia, nor to exhaustion, nor to any toxic action. There are different degrees of normal sleep, estimated according to the strength of the stimuli necessary to awaken the sleeper to a consciousness of his surroundings. The lightest is mere drowsiness, in which, although the person is not directing his conscious attention to surrounding objects, he can still be aroused by slight stimuli, such as ordinary conversation or a light touch. The next is sleep with dreams, when the sleeper is unconscious of his surroundings but the psychical centres are still active, though uncontrolled. And under the influence of dreams, while the cortical motor centres are still active, he may perform motor actions, constituting the well-known somnambulism. But this, in health, is rare, because ordinarily the cortical motor cells are dull at the same time as are the sensory cells. Still more pronounced is the sleep which is deep and dreamless. This, under pathological conditions, merges into what we call stupor, and ultimately into coma. The chief distinction between sleep and coma is, that a sleeping person can be aroused, whereas a comatose person cannot.

(a) Delivered at the Polyclinic, Chenies Street, London, February 19th, 1907.

Let us now pass to the consideration of some disorders of sleep. There may be pathological drowsiness, the commonest instance of which, perhaps, is that of the anæmic young woman. This may be partly toxic, from loaded intestines or possibly from decaying teeth, or other sources; but it is mainly vascular. The heart in these cases has but little energy, and the vessels throughout the body are flabby and deficient in tone, and therefore in the erect posture the vessels of the brain are badly filled. If the patient sits down during the day, she feels drowsy; but when she lies down at night the conditions are altered; the brain becomes hyperæmic—still from want of vascular tone—and she accordingly lies awake. Therefore in treating the anæmia we often administer digitalis, combining it with iron, and bromide of potassium. Then the day drowsiness disappears, and the patient is able to sleep at night. Myxœdematous patients are habitually sleepy and stupid, probably from toxæmia; so are many idiots and cretins. And after a severe fit it is not uncommon for an epileptic to fall into a deep sleep. No doubt this sleep is largely due to the toxines produced by the nervous system and by the muscles during the fit. The drowsiness produced by a combination of exhaustion and extreme cold, as in the Arctic regions, is very striking; and it is probably largely the result of deficient circulation, and unless the heart be vigorously stimulated, the sleep is liable to pass on to coma and death. The sleep induced by gazing into a bright fire on a winter's afternoon is something different; it is probably a mild variety of hypnotic sleep. The continuous red glow acts on the optic nerve by a summation of stimuli; it is not merely the temperature, because in the same temperature if the fire be not seen, drowsiness is not so likely to occur. The church drowsiness is also probably explicable on the "summation of stimuli" idea. There are several elements: the soothing monotony of the preacher's voice, the sitting posture of the listener, who, of course, has the additional excuse of cerebral anæmia, and there is the common habit of closing the eyes to avoid visual distractions. This does not apply to "revival" services, where the conditions are very different.

There is also the drowsiness of impending diabetic and uræmic coma, both toxic in origin. Also there is the remarkable "sleeping sickness," which is endemic in certain parts of Africa, and is associated with trypanosomes in the blood, glands, and cerebro-spinal fluid. The drowsiness is no doubt due to some toxine produced by the parasite. In the later stages there is perivascular cerebral infiltration around the cerebral vessels, a variety of chronic meningo-encephalitis.

Then there is narcolepsy, in which the patient suddenly falls asleep in the middle of whatever he may be doing. These cases are usually hysterical.

The hypnotic state is another condition which is analagous, in some respects, to ordinary sleep, but time does not allow us to discuss it here. Suffice it to say that the phenomena of hypnosis may be produced by continuous monotonous stimuli—visual, auditory, or other, aided by suggestion.

Nightmares are horrifying dreams. which produce so much distress that they sometimes wake the person up. They are generally toxic in origin. The commonest cause of nightmare is gastro-intestinal fermentation; we know what the proverbial lobster supper is capable of. They will occur again and again in a child, and it is curious that the character of the nightmare in the child is generally the same each time. In children gastro-intestinal fermentation is a very important factor. Still more frequently we find that the child has got adenoids, which interfere with respiration, and produce a degree of carbonic acid poisoning which acts as a narcotic. Attention to the gastric condition or to the adenoids generally corrects the night-terrors.

Patients with tropical abscess of the liver are particularly liable to horrible dreams, so much so, that they may be afraid to go to sleep; big sturdy soldiers fear to fall off to sleep. Doubtless the cause here also is toxic.

Nightmares are also fairly frequent in those who have aortic regurgitation. Here the cause is probably not toxic, but vascular, due to the irregularity in the blood supply and to pulsation in the cortical capillaries.

Lastly, there is insomnia, or sleeplessness. These cases may be divided into two great classes: (1) Extrinsic; (2) Intrinsic.

Extrinsic insomnia includes those cases in which the sleeplessness is secondary to some outside cause, not necessarily associated either with the brain or with any of its blood vessels. For example, physical pain of any sort will keep a patient awake; so will a cough, or vomiting, frequency of micturition, or diarrhœa, or pruritus. And, of course, in these cases we do not give a hypnotic; we treat the primary symptom, and if we succeed, sleep follows naturally. This group also includes emotional insomnia. This latter is much more often the effect of grief than of joy; and it is more often associated with fear or apprehension for the future than with sorrow for the past. When a pleasurable emotion does cause insomnia, it is generally the anticipation of some happiness, and one in the near future. A man will not lie awake because someone is going to leave him a fortune twenty years hence; but he may spend a sleepless night on the eve of his marriage. The treatment of emotional insomnia, apart from assuaging the patient's sorrow—which is often beyond our sphere—is best accomplished by giving a cerebral sedative, such as a mixture of chloral and bromide. The insomnia of extreme joy we are seldom called upon to treat; but if the patient becomes too excited, we can give cerebral sedatives here also.

But we are often consulted about the other kind of insomnia, the intrinsic. This may be due to vascular, or to toxic, or to nervous faults, or to a combination of all three.

First, as to vascular insomnia. The brain may be hyperæmic; this renders sleep impossible. Hyperæmic insomnia may be of the high-tension type, or of the low-tension type. In high-tension insomnia the patient is often the subject of general arterial sclerosis, or of renal disease, and the hyper-tension is readily demonstrated by the Riva-Rocei sphygmo-manometer The best remedy for such cases, as Broadbent has so long urged, is to give a mercurial aperient, such as blue pill, or calomel, two or three times a week. Of course, we must also lay down general directions as to diet, &c., and regulate the mode of life. Hyperæmic low-tension insomnia occurs in anæmic and neurasthenic patients, as we have already seen. And it is characterised by the fact that when the patient sits upright in a chair she feels drowsy, whereas when she lies in bed at night the brain is over-filled with blood, and consequently she cannot get to sleep. In these cases the best remedy is a cardio-vascular tonic, such as digitalis, and moderate doses of bromide of potassium. Hyperæmic insomnia, whether of the high or low tension form, is generally associated with cold feet; and if the patient's feet can be got warm the cerebral hyperæmia tends to become alleviated. A cup of hot soup or hot milk will cause temporary abdominal hyperæmia, and thus relieve the cerebral congestion.

Insomnia may be one of the distressing features of chronic heart failure. As the patient is dropping off to sleep, he suddenly starts up with a feeling of suffocation, gasping for breath. This form is probably due to deficient circulation in the medulla oblongata. We treat it by cardiac tonics, possibly combined with one of the non-depressant pure hypnotics, or even, in selected cases, with morphia, which we must administer cautiously and combined with atropine.

Next, there is toxic insomnia, and this is one of the commonest varieties met with in practice. Many of these cases are associated with gastric or intestinal fermentation, and especially with dilatation of the stomach. The symptoms are very characteristic. The patient falls asleep, but after an hour or two—the period varying according to the amount of dilatation present, he wakes up, perhaps after a horrible dream; he has profuse sweating, or some gastric uneasiness, and he will have a "sinking feeling" in the abdomen, with a craving for food. If he eats a biscuit, or something of the sort, his stomach contents become diluted for a time and he feels relieved. And this may mislead the patient into thinking that his insomnia is due to exhaustion from want of food, which is far from the fact. During his waking hours the patient is usually depressed, even hypochondriacal, he may be almost melancholic. When we have such a history we should carefully examine the patient's abdomen, and if we find the physical signs of dilated stomach we must treat the patient accordingly: put him on dry diet, free from starchy foods, excluding green vegetables, and attend generally to the intestinal functions. Meanwhile, we should administer gastro-intestinal antiseptics, such as carbolic acid, creasote, or β Napthol, or sulpho-carbolate of soda. To give hypnotics in such a case, without correcting the gastric condition, is worse than useless.

I must now refer to the sleeplessness produced by chronic excess in the use of alcohol. This sleeplessness sometimes culminates in delirium tremens. There is also the insomnia of acute fevers, and that also is toxic. In the insomnia both from fevers and delirium tremens, sleep can often be best induced by putting the patient into a cold pack, or by wet sponging. Tobacco smoking in excess may cause insomnia, partly by a toxic action on the nerve cells, and partly by its influence on the circulation. Strong tea and strong coffee sometimes act in a similar way.

There is also a primary or nervous insomnia, and that is generally due to over-fatigue, especially mental. We see it in busy professional and business men. But in most cases of insomnia there are several factors. There is not only the toxines of exhaustion and of hasty, ill-digested meals, but also a succession of powerful mental stimuli all day long, causing a persistent cerebral hyperæmia.

As to treatment, in cases of primary insomnia, besides correcting anything in the way of gastro-intestinal fermentation or any vascular fault, we should make it a golden rule, I think, to send every case away for a complete holiday. And instances of pure insomnia are proper cases for the employment of pure hypnotics, which have a direct sedative action on the psycho-sensory cortex. The names of these hypnotics are legion. Amongst the most reliable is, perhaps, the old-fashioned paraldehyde. It has a somewhat nauseous taste, but I do not regard that as any drawback, because it will prevent a habit being formed. We do not often hear of people contracting the paraldehyde habit. Other reliable hypnotics are chloral, sulphonal, and veronal. Never give a patient *carte blanche* to take the drug himself; self-drugging with hypnotics is highly dangerous in the layman, and still more so in the medical man, who should never prescribe for himself. He should rather go to his bitterest professional rival.

There are other drugs, even more powerful than those I have mentioned, for example, hyoscine and morphia. They should be resorted to only in cases of obstinate insomnia. In extreme cases of excited mania or melancholia we are justified in giving $\frac{1}{100}$ gr. of hyoscine hypodermically, or we may give morphia $\frac{1}{3}$ gr. with $\frac{1}{100}$ gr. of atropine. It is very important for every mental case to have sleep. Persistent insomnia in cases of insanity is of serious omen, and all modern alienists insist on sleep-charts being kept. Severe insomnia extending over a month in a case of insanity makes the prognosis as to recovery very gloomy indeed.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by J. Bland-Sutton, F.R.C.S., Surgeon to the Middlesex Hospital and Senior Surgeon to the Chelsea Hospital for Women. Subject: "The Value and Fate of Belated Ovaries."*

The Lord Mayor and Corporation of Cardiff, in order to commemorate the recent visit of Their Majesties and H.R.H. The Princess Victoria, intend to present 40,000 specially designed boxes containing milk chocolate to the school children of that city, and have entrusted the execution of this large order to Messrs. J. S. Fry and Sons, Ltd., of Bristol and London, Makers to H.M. the King.

Cambridge Lemonade.—Messrs. Chivers and Sons, Ltd., of Histon, Cambridge, have sent us a sample of their "Cambridge" Lemonade, which is already well known for its refreshing qualities. The convenient form in which it is made up—namely, that of a powder—enables it to be used largely for travelling and pic-nics, as well as for ordinary domestic use. The name of Chivers is a guarantee as to quality.

ORIGINAL PAPERS.

THE GENERAL PRACTITIONER.

III.—HIS PRACTICAL NEEDS.

By J. LIONEL TAYLER, M.R.C.S., L.R.C.P.Lond.

THESE are, I think, four—(1) an efficient literature that is representative of his requirements; (2) leisure to study and to rest with less fear of interruption; (3) incentives for the fostering of research desires; (4) freedom from excessive competition.

(1) *An Efficient Literature.*—This point I have already alluded to in my last paper, and here, I hope, it only needs emphasising. Every worker in any form of activity needs a *representative*, trustworthy literature composed of good reliable text books, *that have a reference value to such worker*, and periodicals, also reliable, dealing with more transient aspects of his employment. These are exactly what the general practitioner lacks because he is still looked upon as a subordinate when he is an independent investigator whose results ought to be related to other medical investigators.

That general medical literature does not attract and is of little use to the ordinary medical man is proved by the little reading on medical subjects which he undertakes. I remember being the guest of a doctor who prided himself on his efficiency after some forty years of practice, and I think in the main his pride was justified, who though he had distinguished himself at college, and had succeeded both financially and by reputation, had not added, as far as I could discover, one single text-book on any branch of medicine to his book-shelves since his student days, nor did he belong to a medical library. This is perhaps exceptional, though I am sure it is less so than is apt to be thought, but it is certain that new books are very seldom added to the medical nucleus that is acquired in student days, and yet if books were really a help, they would unquestionably be bought if only to compete more favourably with other medical men. *This lack of reading is not true to anything like the same extent, of the consultant and the specialist, hence books must serve their ends better than they do the ordinary man's.*

The reason is obvious: A practitioner who sees a patient once, twice, or even several times, but in each case for a special defined reason, and receives his fee for each consultation is on a distinctly different footing from the one who may be called in for any cause, who is frequently on terms of intimacy with the family, and may have all kinds of questions asked him. A book dealing solely with defined diseases satisfies the former, but for the latter it is all but useless.

Such questions as the advisability of marriage for a delicate but not diseased woman or man; advice on girls' or boys' education in relation to their health; on choice of a house, the soil it should rest on, its situation, drainage and sanitation; heredity; diet and food adulterations; exercise and clothing which are all quite legitimate ones, are not adequately treated in any book, so far as I am aware, that is in existence, and are frequently not alluded to. Then there are certain issues that a doctor is quite justly expected to give an authoritative opinion on, such as hydropathy, homeopathy, vivisection, vaccination, hypnotism, faith healing, Christian Science, patent medicines, and he may turn in vain to any one, two, or three works of reference for brief, reliable interesting statements on these subjects. Again bodily temporary or permanent conditions which are not due to disease—and frequently depend upon some error in diet, exercise or vocational habit—such as constipation, flatulence, headache, sleeplessness, but are nevertheless very difficult to treat, are mostly unconsidered. Occasionally one is asked such a question as this, and in the future it will be a frequent one: "Will you please examine me, and tell me if I am healthy?" and to this may be added the still harder point: "and how am I to keep so?" Though insurance books are some help they are really of much less use than would be thought as all the old assumptions of size, weight, height, etc., have broken down, and we simply do not know if a given man is naturally small like a Japanese, heavy like a Welshman, or light like an Irishman, or is unhealthily undersized, heavy, or light. And it is needless to point out that our advice should depend on our diagnosis.

A literature corresponding to the general practitioner's needs is therefore the first essential, and I am convinced that if it existed it would be widely appreciated.

(2) *Leisure to Study.*—The exactions of patients who trouble doctors at all hours of the day and night over quite slight matters must be met. As a student I was once called at three in the morning because a patient wanted a thickened but, he admitted, painless toe-nail cut, and though I have never since had quite so flagrant an example of unreasonableness to contend with, yet, like all other medical men, I have time and again been troubled late in the day or at night with the silliest of trivialities. It is quite useless to attempt to do solid reading under the circumstances, as one is always waiting for the call bell, and so a novel that can be picked up and thrown down again accounts for far too much of the leisure at our disposal. Many men do their best work in their carriage while visiting, reading the weekly medical journal and getting their new ideas largely from such source alone. Others rely on chats with brother practitioners. But in all cases the result is far from satisfactory as most recognise.

The only solution to this difficulty of constant interruption is that which many qualified men have already adopted, namely, of graduating the fee to the lateness of the hour when one's advice is sought, and except during fixed consulting hours, charging one fee before twelve, one and a half between twelve and six, and two fees after this.

Such a rule would apply to all classes alike, it creates no invidious distinctions and it gives the patient the option of sending if the need is great, while it appears to be at the same time an effective deterrent to unreasonable demands. Something of this nature is required to prevent medical men's leisure being wasted.

Of course some arrangement should be made also in reference to obstetrical cases. Beyond a certain number of visits extra fees should be charged for those that the patient is herself responsible for. There is at these times all the difference between the genuinely anxious and the fussy patient and the latter should be made to realise that the trouble that she causes is a costly matter for herself.

If practitioners would combine by some such scheme it would in the end be beneficial not only for the profession at large, but for the general public's own interests, as a higher level of capacity would be possible for medical men to attain to.

(3) *Incentives to Study.*—There are few more curious anomalies than the position of the medical man in regard to medical research. In every other occupation a man has at least the possibility of reward for original investigations. In medicine alone the worker may not profit by the creation of improvements in his calling and yet the person who is not medical may.

It must of course be admitted that the medical position is a peculiar one. Everything must be done to prevent health being considered from the commercial aspect. Advertising is for this reason wholly discreditable. Also to make a profit from the sale of drugs or instruments is equally unsatisfactory. Yet it must be evident to every person who thinks over the matter at all that to deprive a medical man of all remuneration for his labour ***must tend*** to make him less interested in the original aspects of his pursuit and this is an evil of incalculable magnitude.

Further, by removing the true pioneer from his rightful position and not keeping the place vacant, but allowing the little trained chemist and the untrained quack to compete for what is denied to the medical practitioner must, and as a matter of fact does, result in the exploitation of worthless products by adventurers on its worse side and on its better by the production of new drugs that may be of value—but since they cannot be tested therapeutically by chemists, however efficient—are for a long period unsupported by clinical testimony as to their special actions. It is neither to the interest of the patient (who is treated by a medical man who has little incentive to develop his skill and who is imposed upon by untrue advertisements of patent medicines) nor to that of the doctor that this state of things should continue.

To obviate this surely it would be possible to have new remedies tested by specially appointed Government experts, whose own stipends must be unalterable ones, and an award granted to the discoverer for his legitimate labours, which though not large should at least compensate him for his effort. This sum, if it were fixed either in the form of a small unalterable annuity, or by payment of a given amount of money that would be regarded as complete compensation for the discovery, would enable the new product or contrivance to become at once public property, while the discoverer's financial interest in it would at the same time cease. If, further, no other means of patenting any new drug or instrument were legal and the advertising or selling of medical things by unqualified persons was made criminal, a fresh stimulus would be given to the chemist and the medical man in their respective occupations, while the removal from social life of the advertising quack who influences so prejudicially many thousands of people would be an unquestionable gain to humanity.

There is of course nothing new in this proposal. but surely some such recognition of service is desirable. Obviously until labour in this direction is made in some degree remunerative it is impossible for any man who has to earn his living, to spend much effort in a direction where he cannot expect the least return. To thus crush out incentive by giving it no outlet is neither wise national nor individual policy and until such individual incentives are in existence medicine can never take its true position in relation to other scientific studies.

(4) *Excessive Competition.*—Lastly, it is a fact, regret it to what extent we may, that owing to growing competition the various members of the medical profession are becoming increasingly hostile to each other.

Some means of checking this tendency must be found. A minimum fee should, I think, be fixed by the General Medical Council, and doubtless simpler quieter modes of living would accomplish much.

In conclusion, it is along lines such as these that the development of medicine must take place. We must come together on a broader and more friendly basis; we must have more leisure and be treated more considerately by the general public; we must have incentives to study and not see the quack reaping in districts that are rightfully our own; and our literature must recognise and cater for the needs of the general practitioner. Finally by removing the stigma of inferiority from the ordinary medical man by giving him a share in the control of medical institutions and by realising that he has at his command information that can be obtained from no other source it is reasonable to hope that a newer and larger horizon will be revealed to us.

POOR-LAW AND SANITARY ADMINISTRATION IN IRELAND. (a)

By SIR CHARLES A. CAMERON, M.D. F.R.C.P.I., D.P.H.Cantab.

Chief Medical Officer of Health for Dublin.

The Sanitary Acts are administered in Ireland by the following bodies:—1st, the Local Government Board, the supreme public health authority of the country; 2nd, the county boroughs; 3rd, the urban district councils; 4th, the rural district councils.

The Local Government Board has certain powers vested in it by statute, which enables it to supervise the boards of guardians who have charge of the pauper poor, sick or well. The Board must approve of the appointment and dismissal of officers of the guardians; its auditor examines their accounts and makes surcharges if payments of money have been illegally made. If the Board considers that the guardians have neglected their duties, it may supersede them by the appointment of vice-guardians. The Board has much the same power in reference to the boroughs and urban and rural district councils. It must approve of the appointment and dismissal of sanitary officers, and of their salaries and increases of salaries. This practically secures fixity of tenure to the medical officers of health, who are appointed by the sanitary authorities, and in which respect they are in a more secure position than the medical officers of health in England and Scotland.

The Local Government Board contributes to the salaries of the sanitary officers of the local authorities. Dublin received last year more than £2,000 on account of the salaries of the medical superintendent officer of health and the sanitary sub-officers. For some years up to 1902 the Local Government Board paid one half of the salaries of the sanitary officers. In that year an Act of Parliament was passed, which fixed the contribution for that year as the maximum sum that in future could be given. As a result of this Act, the Local Government Board cannot contribute to the increase of salaries or to the salaries of new appointments, if by so doing its contribution would exceed the grant of 1902.

(a) Read at the Conference of the Royal Sanitary Institute, Dublin, June 17th, 1907.

The borough councils are empowered to appoint medical superintendent officers of health, executive sanitary officers, and sanitary sub-officers (another name for inspector of nuisances, or sanitary inspector). They can establish hospitals and work them, or contribute to their maintenance, or do both. Dublin has a smallpox hospital in connection with its Sanitary Department. It has no Corporation general or fever hospital, but it contributes between five and six thousand pounds annually to hospitals under private management. In addition, the Public Health Committee are empowered to pay for the maintenance of fever patients in the fever hospitals, or in the fever wards of the general hospitals. All the powers which Dublin and other county boroughs possess in reference to the appointment of sanitary officers and contributions to hospitals are also enjoyed by the urban and rural district councils.

The Irish Public Health Act of 1875 constituted all the poor-law medical officers *ex-officio* medical officers of health. They were paid by the boards of guardians, but when their districts were situated in towns having sanitary authorities, their salaries were fixed, though not paid, by those authorities. This anomaly ceased on the passage of the Irish Local Government Act, which transferred the payment of the salaries of the medical officers of health from the boards of guardians to the governing bodies of the counties and boroughs, and of the newly-created rural district councils. This Act transferred all the sanitary functions of the boards of guardians to a newly-created set of authorities, termed rural district councils, whose functions are practically the same as the sanitary authorities of the towns. They are practically composed of the boards of guardians, but they have sometimes different chairmen and clerks. They pay the salaries of the *ex-officio* medical officers of health, sanitary sub-officers, &c.

It is now generally conceded that it was a mistake to have converted *nolens volens* the dispensary physicians into medical officers of health. Many of them disliked the new functions, especially as, with very few exceptions, their salaries were very small, often £10 a year. In 1900 a Commission was appointed by the Local Government Board to inquire into the causes of the high death-rate of Dublin. One of the recommendations was that an assistant medical officer of health should be appointed, and the sixteen *ex-officio* medical officers of health relieved of their functions. No authority in Ireland has the power to abolish the *ex-officio* health officers. It has been suggested that in the next proposed Dublin Improvement Act a clause should be inserted to discontinue their services. I doubt very much that Parliament would pass such a clause, for as a rule sections of general Acts are not in any important manner repealed by local Acts. In a general sanitary Act for Ireland, the *ex-officio* health officers might, of course, be dealt with.

One great difficulty in depriving the dispensary physicians of their sanitary functions is the question of compensation. If they were compensated by retiring allowances, then for many years to come the local authorities would have to pay a double set of medical officers of health. Most innovations and improvements are, however, attended with expense; and the abolition of the *ex-officio* health officers, and their replacement by whole-time officers, would (so far, at least, as rural districts are concerned) be worth the expense involved by it. So far as the large towns are concerned, the district medical officers of health perform, on the whole, very good sanitary work. In the rural districts they are handicapped very largely. They have not efficient sanitary sub-officers. The rural district councillors are practically the boards of guardians, who elect and pay them as dispensary physicians or medical officers of the workhouses. The health officers, whenever they make sanitary reports, are not unlikely to give offence to some one or other of the rural district councillors. This is particularly the case as regards the hygiene of the dairy and farmyard. A considerable proportion of the milk supplied to the towns comes from the country. The sanitary sub-officer who is generally also the relieving officer, and who has a salary of only a few pounds a year, can hardly be expected to give much attention to the hygiene of the dairy and cowsheds. He is not qualified by the possession of a certificate of competency to act as a health officer granted by such bodies as The Royal Sanitary Institute. I think it may safely be assumed that in the greater number of the rural districts in Ireland the sanitary laws are practically a dead letter.

It would be most desirable that the Department of Agriculture and Technical Education should take over from the sanitary authorities the supervision of all places in which milk is produced. For the administration of the Disease of Animals Act and the Orders relating to dairies and cowsheds, it has a staff of nearly sixty veterinary surgeons. By an increase of this staff and the appointment of inspectors not veterinary surgeons, but having some knowledge of rural sanitation, the health of dairy stock of the country and the purity of the milk would be far better attended to than they are at present.

Whether or not the *ex-officio* medical officers of health should cease to exist, the county council ought to be empowered to appoint medical officers of health and sanitary sub-officers. If the officers' functions ceased, the sanitary staff of the county would have to be larger than if there were no district medical officers. In England and Scotland, as well as in Ireland, there are district medical officers of health; but that did not prevent the establishment of county officers with powers to act in every district, and to review the proceedings of the local authorities. I would be glad if this Conference would pass a resolution urging the Government to introduce a Bill for the appointment of County Medical Officers of Health.

DR. F. H. SCOTT, who wishes to continue his researches into the metabolic processes of nerve-cells has had the accrued income of the Gunning Fund placed at his disposal for the purpose.

TWENTY-THREE YEARS OF GYNÆCOLOGICAL PROGRESS. (a)

By W. D. SPANTON, F.R.C.S.Eng.,

Consulting Surgeon, North Staffordshire Infirmary, &c.

To attempt a general survey of the work accomplished by our society during the past twenty-three years would be quite impossible in the time at my disposal. It becomes a duty, nevertheless, to recall some of the more important features of it, which afford a convincing proof of its usefulness and of the value of the results it has accomplished.

To begin with, I have to revert to the early days of recognised gynæcology in this country, when strong convictions and abundant moral courage were vitally necessary. These attributes fortunately some of our pioneers possessed, and enabled them to lay the foundation for the scientific study of British gynæcology as a distinct and important branch of special surgery.

The Foundation Meeting was held on December 27th, 1884; and I find, on looking through the first list of officers of the Society, only one of the vice-presidents is still with us, the veteran Dr. C. H. Routh, though of the original Council we have still one-half remaining among our Fellows. The objects were expressed to be "to promote and encourage the science of gynæcology," and Dr. R. Barnes then said he was "sure its existence would be abundantly justified by honest and useful work." This prophecy has, we know, now been abundantly fulfilled.

The first specimen shown by Dr. Wallace was a typical one of degeneration in multiple uterine myomata, where hysterectomy had been performed; and it seems to strike the key-note of one of the most important tunes which our society has had to sing—that of early surgical interference in all such cases. But the most advanced surgeons on the same occasion concurred in the speaker's remarks that "to extirpate a tumour simply because it was a tumour, which gave little or no trouble, and which in all probability would finally disappear, implied taking a responsibility on the part of the surgeon which he ought to decline." This view, I am glad to say, has been reiterated in an emphatic manner at one of our recent meetings. No one subject has been so fully dealt with as that of uterine tumours; and valuable investigations have been recorded, throwing light on their pathology and treatment; but I do not find anyone bold enough to enter upon their causation. That seems as much a mystery as ever, and might form a good topic for the new Royal Society of Medicine.

We find in the very early days (1884) some discussions on the Listerian mode of treatment in laparotomies and kindred operations; and a divergence of views was even then beginning to manifest itself in vigorous language. At that period numerous cases were brought forward of ovarian and parovarian tumours of all kinds, and uterine appendages removed for a multiplicity of conditions. It was about this time an outcry arose against what some persons deemed the too frequent and indiscriminate operations of this class; and although, in looking back, it is evident enough that the evils were greatly exaggerated, a more conservative policy was the direct result, so that good came of it.

One condition, however often referred to—that of diseases of the Fallopian tubes—was in its early stage of evolution, for we find frequent reference to the difficulties encountered by the best operators of that day, notably Lawson Tait and Dr. Bantock; the same difficulties as are encountered still, but with more accurately defined knowledge how to deal with them, derived from the experience of operators in the past. The treatment of pelvic abscess by abdominal section has been frequently dealt with, being first brought prominently forward by Dr. Richard T. Smith and Mayo Robson. Associated with this, a discussion on "Puerperal Septicæmia" elicited some emphatic remarks from Lawson Tait and Robert Barnes, that "whenever pus formed and collected in the abdomen and pelvis, the indication was strong to make an incision into the abdomen and give it exit."

The subject of Porro's operation (spoken of as amputation of the uterus), brought forward by Dr. Godson, drew attention to its advantages, under specified conditions, over that of Cæsarian Section.

That all-important disease, cancer of the uterus, has received a large share of attention from this society, and the consensus of opinion is that, like cancer elsewhere, if it can be thoroughly removed early enough a cure will follow; and although, in advanced cases, no remedy has yet been found which will effect a cure, much may be done by removal of the diseased tissues in various ways, to prolong and make more comfortable the patient's remaining life. Early hysterectomy, all agree, offers the best chance for the patient. The treatment of uterine tumours by electrolysis, as advocated by Apostoli, found favour with a minority only, and was strongly condemned by others—chiefly those who had never tried it. That it has its uses, few will deny; though it seems to have fallen almost into disuse now. Another important aspect of myoma in connection with pregnancy has been before us, which illustrates forcibly the close association of obstetrics and gynæcology. As in most things, there are two sides to the question, and it is well to hear both before arriving at any definite conclusion as to the right course to adopt in every such case.

We find scattered among the records many subjects of general interest, which, having a special bearing on gynæcology, have been discussed from that standpoint. Among them, the dangers of the use of morphia, conveying a very suggestive note of warning.

The treatment of uterine prolapse has been fully dealt with, and the ventral methods compared with the vaginal freely discussed. When the causes are so diverse, the treatment must necessarily be very varied too; and it becomes quite impossible to do more than indicate what may be considered the best mode of treatment for well-defined conditions—no universal rule is possible.

Of displacements of the uterus, with reference to mechanical support, much has been said; but it would seem that opinions as to the best method remain as varied as ever. I fear that, until men and women are made of some more rigid material than living flesh and blood, there always must be a difference of opinion regarding the treatment of conditions which cannot, in their very nature, be fixed quantities. As we proceed, we find such matters as cholecystotomy and nephrolithotomy described. These were, to a large extent, novelties then; the beginning of great things for those branches of abdominal surgery which have now arrived at the stage of having specialists of their own. The very wide subject of dysmenorrhœa has, at various times, been freely discussed, and, each time it comes up, some new light is able to be thrown upon it. Social matters of interest have been dealt with from time to time—notably the Midwives Bill introduced in 1890, since in a modified form passed into law, conducing without doubt to the safety of parturient women who were formerly in the hands of ignorant persons.

During our last short session, many interesting subjects have been discussed, most of them having a practical bearing on everyday gynæcological work rather than of an academic character. Among them may be mentioned membranous dysmenorrhœa, a subject of importance to the general practitioner, and about which much has yet to be learned.

We are indebted to Professor Jacobs, of Brussels, for bringing before us the subject of the radical treatment of prolapsus uteri, more especially by means of an extensive operation he described. This led to a valuable discussion, and the views of many Fellows who took part in it were freely expressed, and will be found recorded in the valuable volume (the last, unfortunately) of our *Transactions*.

The important subject of the surgical treatment of inflammatory diseases of the uterine appendages was

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(a) A Valedictory Presidential Address read before the British Gynæcological Society, July 11th, 1907.

once more brought forward by Dr. A. E. Giles—another reminder of vexed controversies which a few years ago would have provoked acrimonious debate. It is one of those matters which time and experience have helped to make clear, and enabled certain rules for guidance in treatment to be laid down, which must prove helpful to less experienced practitioners. Reference was very suitably made to the exhaustive work in this department carried out by Dr. Cullingworth; and there is no doubt that he, and Lawson Tait, were those chiefly instrumental in showing the necessity for surgical action in cases of this class. Now that they are able to be better differentiated, and the conditions more accurately defined, what was once decried as an empirical, is now fully accepted as a scientific mode of treatment. For this result we have wholly to thank the gynæcologists.

Another interesting paper brought before us, rather surgical than gynæcological, by Mr. Stanmore Bishop, was that of movable kidney. The influence of this condition on a woman's life was entered into, and led to some varied views. Some would look on it rather as a symptom or an effect than a cause; and a fear was expressed lest surgery should take the place of other measures. For my own part I am firmly convinced that a mobile kidney is often a sole cause of some of the most troublesome ailments in women, especially on the left side, where it sometimes simulates very closely the symptoms of gastric ulcer—on the right side, its frequent association with appendicitis is also easy of explanation. But to ascribe, as has been done by some authors, such remote troubles as insanity to a mobile kidney, seems to me beyond the ken of modern gynæcologists, at any rate.

At our last meeting, we had the advantage of having brought before us, by one so eminently qualified to speak as Mr. Mayo Robson, the question of the treatment of general peritonitis. This is, indeed, an important one for all surgeons, and needs all the light that can be brought to bear upon it by skilled minds. On this occasion, as usual, diverse views were expressed; but one and all agreed that the modern treatment of this condition, by which every effort is made to assist nature rather than to thwart her efforts, has been a great advance. To open the abdomen early; whenever possible, to remove the cause, and then trust to natural processes to complete the work is what we now aim at. Those who attempt too much, equally with others who stand by and do too little, usually come short of success. It was especially fitting in a practical society like ours, that this subject should have recrudesced, and led to a discussion which is certain to result in good.

It would be a grave dereliction of duty on my part if I were to omit some reference to the indefatigable and valuable labours of some of our Fellows, who have, by their energy and their influence, overcome the difficulties which were inherent to the union of our society with the new Royal Society of Medicine. To Dr. Macnaughton-Jones, Mr. B. Jessett, Dr. Slimon, and Dr. Beckett-Overy especially, our warmest thanks are due; and I feel sure that, in years to come, when the Obstetrical and Gynæcological Section of the Royal Society of Medicine is thoroughly established, everyone will look back with the utmost satisfaction, and with grateful feelings, to those who have been instrumental in its accomplishment.

One achievement on which the Society has good reason to congratulate itself, is the series of valuable *Transactions* which have been published, and will remain as a monument of practical gynæcological literature. It is not too much to say that the success which has attended the society is, in no small measure, to be attributed to the full and admirable manner in which its work has been recorded, and correlated with that of other countries

Sir Thomas Browne wrote that "as the work of Creation was above Nature, so is its adversary annihilation, without which the world hath not its end, but its mutation." So of our society. Its birth is now to us "a sleep and a forgetting," and "the soul that rises with us, our life's star," will find its apotheosis in the higher life which lies before us in our new sphere.

Now, to our old Society, we have to bid "Farewell."

"EXTINCTUS AMABITUR IDEM."

CLINICAL RECORDS.

CASE OF FIBRO-MYOMA OF THE VAGINA.

By J. H. SWANTON, M.D.,, M.Ch., M.R.C.P.Lond.
Physician for Diseases of Women, Kensington General Hospital, etc.

The patient, C.G., from whom this growth was removed, was æt. 40, a widow, whose occupation was that of cook.

She came to hospital complaining of pain in her back and lower part of abdomen, frequency of micturition, and painful defœcation. The only previous illness was described as inflammation of the bowels. Menstruation commenced at 14 years of age, regularly appeared every 28 days, and lasted seven days with scanty loss. She had pain occasionally before each period. The patient had been pregnant five times, her eldest child was æt. 18, and she had four miscarriages, the last having occurred five years ago, after a pregnancy of three months. She nursed her child for nine months.

Her present illness began three months ago with pain in her back, caused by standing. There was a red vaginal discharge which came on every fourteen days. There was dysuria without frequency of micturition. She had been getting thinner recently. The patient was thin and had an anxious expression with agitated manner. The superficial reflexes were increased. The abdominal muscles were rigid. There was a red vaginal discharge with a faint odour. The urethra was drawn upwards; the uterus was enlarged, and its consistence increased; the fundus was retrodeviated and not freely movable. Both external and internal piles were found.

In September, 1906, she returned, complaining of backache. The uterus was now movable, A nodule was found in the vaginal vault at the junction of the anterior and posterior left quadrants. The mucosa could be removed freely over it. The uterus was anteverted and a suitable pessary inserted. In October, 1906, the tumour was found to have become enlarged and the surrounding tissues were less sharply defined. In February, 1907, the nodule had not altered much, but the surrounding infiltration was greater. On conjoined manipulation the uterus was found to be painful, In March, 1907, the patient was admitted, when the uterus was curetted and the vaginal tumour removed at the same time, owing to its increased growth. An incision was made into the mucosa and the tumour found to be attached to the muscular wall by a pedicle, which was cut through after ligaturing and the growth then removed. The wound was sutured with iodised catgut and healed without complication.

The tumour measured three-quarters of an inch in its longest axis and one-third in the shortest. The surface was irregularly lobulated, of pearly white colour, with subcapsular areas of hæmorrhage. On section a capsule was found externally enclosing a mottled central portion made of irregularly-arranged whitish tissue in strands surrounding areas of grey tissue; also a looser tissue of the same kind on one side immediately under the capsule. After serial staining of one set of sections with hæmatoxylin and eosin and another with Van Giesson's fluid microscopical examination showed that the fibres of the capsule were loosely arranged with polymorphonuclear cells scattered between, and in other portions some extravasations of blood were seen.

The central portion consisted of white fibrous tissue arranged in whorls and unstriped muscular tissue irregularly interspersed. The arterioles in the central portion showed hypertrophy of the middle coat, as observed by Mr. Stanmore Bishop, and described in a communication read before the British Gynæcological Society and recorded in the XVII. Volume of its Transactions.

The patient was discharged in seven days after the operation and convalesced in a satisfactory manner.

In connection with the etiology of these growths Cornil and Ranvier have associated them with syphilis, but in this particular instance sufficient evidence was not forthcoming.

Fibro-myomata of the vagina are rare. Machenhauer has collected reports of seventy cases, and stated they were found in women between forty and fifty years of age. They varied in size from a cherry to that of a fœtal head, and are found in the upper part of the anterior wall, being chiefly sessile. The surface may occasionally ulcerate.

CASE OF CYST OF THE CLITORIS.

The patient from whom this cyst was removed was a dancer, æt. 20, who complained of a painful swelling on her vulva early in May, 1907. Her menstruation, which began at fourteen, appeared regularly every twenty-eight days, lasted four, and was scanty. There was a thick yellow inter-menstrual discharge. She had been married for two years, and was pregnant a year ago, but aborted after two months. Since then her menstruation has been irregular, being more frequent and of longer duration.

The onset of this growth was dated from an injury received while dancing, what she described as the "cobbler" dance, three months previously.

The swelling gradually increased in size, but after manipulation three days previously it became rapidly larger, more painful, and accompanied with dysuria. The patient gave a history of alcoholism. The tumour became smaller during menstruation.

On examination the clitoris was found to be the seat of a fluctuating tender, dusky, tumour about three-quarters of an inch across. The bifurcation of the anterior extremity of the left labium minus was widely separated owing to the size of the cyst. As the symptoms were urgent the tumour was tapped, giving exit to a quantity of coagulated blood mixed with a thick oleaginous fluid followed by a thin greyish fluid with a faint odour. The patient experienced such relief that further treatment was refused. In ten days afterwards, however, she was admitted into hospital owing to a return of pain and swelling. The growth had extended under the anterior commissure and vestibule to the right side. The tumour was removed by making a triangular incision reaching from the suspensory ligament to a point about an inch outside each labium minus, and another across the vestibule. The cyst was dissected out without rupture. Hæmorrhage was free, but easily controlled by deep mattress sutures of catgut, the skin being united by continuous catgut sutures.

The growth consisted of a thick walled oval cyst about 1½ inches in length and ¾ inch across. There was a small opening anteriorily from which purulent fluid exuded. The wall was three-sixteenths of an inch in its thickest portion, and diminished down to a membrane anteriorly. The contents consisted of pus and fatty debris, but no cholesterin was found. The anterior two-thirds of the inner surface of the cyst wall was hæmorrhagic. The inner surface generally was rugose with traces of septa, more marked in the posterior third. On microscopical examination the walls were made up of laminated layers of connective tissue with numerous vascular spaces; more internally the tissue was necrotic with numerous polymorphonuclear leucocytes and lymphocytes. There was no trace of a distinct lining membrane. The differential diagnosis must be made between a dermoid cyst, fatty tumour, sebaceous cyst and chronic abscess. The attachment of the cyst to the skin, the known date of onset, and its position were against a dermoid cyst. The absence of lobulation and the firm consistence would distinguish it from a lipoma. The diagnosis between a sebaceous cyst and a chronic abscess was not so easily disposed of, but the history and structure of wall were in favour of its being a sebaceous cyst in which suppuration had recently taken place.

The patient was discharged convalescent on the sixth day after the operation.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

Double Osteotomy of the Femur for Knock-Knee.—Mr. Arthur Edmunds operated on a female child, æt. 5, who was suffering from an extreme degree of knock-knee. The child was a thin, ill-nourished little girl, who had obviously been the subject of severe rickets, but, with the exception of the deformity of the femora, the mal-nutrition presented no other deformities. When the child lay down with the internal condyles of the femora in apposition, the internal malleoli were separated by about seven inches. The deformity in knock-knee, Mr. Edmunds pointed out, may be mainly due to a curvature at the lower end of the femur, or it may be due also to a curve at the upper end of the tibia. It was very rare to find the curve in the tibia alone. By flexing the leg at the knee-joint, it was always possible to make out the share played by each bone in the production of the deformity. If the femur is alone affected the internal condyles and the malleoli can be made to touch simultaneously when the knees are flexed. For example, if a child be placed on a table so that the knees hang over the edge, the deformity completely disappears. In early stages of knock-knee, while the bones are yet soft, a simple splint will usually suffice to completely cure the deformity; but when the bones have become more firmly ossified—that is to say, when a child is æt. about 5—this mode of treatment is not sufficient, and osteotomy has to be performed. Osteotomy, however, although it seems at first sight such a trivial operation, is very frequently a severe strain on the constitution of these weakly children, and after prolonged immobilisation in plaster of Paris, the legs are often found so weak and wasted that it is a very long time before the child is able to walk. In the present case the child on admission was so poorly nourished that it was not thought advisable to perform an osteotomy, until she had been sent away to the country for several months. Her condition on re-admission to the hospital was very much improved and operation was accordingly undertaken. Many types of osteotomy have, Mr. Edmunds said, been introduced, but the linear osteotomy on the lines laid down by McEwen was perhaps the best. An incision about three-quarters of an inch long, above and in front of the adductor tubercle, was made down to the bone and the osteotome introduced, twisted to 90°, separating during its rotation the periosteum from the bone. The bone was then divided, its various portions being dealt with systematically, and any remaining spicules fractured; the leg could then be brought into good position. The wound was closed with a few sutures. The opposite leg was then treated in exactly a similar manner, and both legs dressed and bandaged to half box-splints. It was felt desirable to avoid the prolonged plaster of Paris treatment, and as soon as the wounds were healed systematic daily massage would be commenced. Massage in fracture not only, Mr. Edmunds said, prevents the adhesions forming between muscles and articular surfaces of bones, but also maintains the nutrition of the limb and enormously accelerates bony union.

In the present case, at the end of three weeks, although both femora had been completely divided, no movement could be detected between the fragments and the child was able to stand alone. The splints were removed, and the child was encouraged to move the legs in bed. After another fortnight's rest the girl was allowed to get up and run about. She was kept in the ward for some time longer in order to make quite certain that the union was stable, and was then discharged six weeks after the operation. Mr. Edmunds pointed out that by treating cases in this way, that is to say by early massage, firm union is obtained much more readily, and the period of convalescence materially shortened.

TRANSACTIONS OF SOCIETIES.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, JULY 11TH, 1907.

Mr. W. D. SPANTON, F.R.C.S., President, in the Chair.

SPECIMENS.

DR. J. H. SWANTON showed a fibro-myoma of the vagina; an account of this case will be found on page 89 of the present issue.

Dr. MACNAUGHTON-JONES said such tumours occurred comparatively infrequently. Up to the last time that he had occasion to collect statistics of fibromyomata of the vagina there had been about 260 cases. Dr. John Phillips brought forward the records of 29 cases which he had collected, up to the beginning of the year 1905. One of the most important points of interest about such tumours was as to whether they degenerated and became malignant. There were certain cases on record in which those tumours had become sarcomatous. Sometimes they assumed a myxomatous character, but as a rule they did not produce any remarkable symptoms. The age of onset did not correspond with that of malignant disease generally, for they occurred between 30 and 50. They were seen far more frequently in the anterior wall than in the posterior wall. They frequently had a pedicle and sometimes were found as multiple sessile tumours. He believed they seldom became malignant.

PROFESSOR TAYLOR said he had met with four instances of fibro-myoma of the vagina, all of them having occurred in the anterior wall, and all were sessile. In one case the growth was recurrent. He operated on four different occasions, removing the growth from the same situation, and finally cauterising the base. In that case he expected to find the tumour was sarcomatous, but he had the satisfaction of knowing that the last operation had maintained its efficacy longer than any before. Three years had elapsed since the operation, and he found that the histological characters of the tumour were those of simple myoma.

Dr. MACAN said it would be an interesting question in the pathology of these growths if we could distinguish between abnormal growths of fibroid tissue in the abdominal wall in the ovaries, uterus, and vagina.

The PRESIDENT said he did not remember having had a case of the kind. It seemed that everything now centred around the possibility of malignancy supervening in what had always been regarded as simple growths, and this was the line of investigation for the future.

Dr. SWANTON, in reply, said none of the speakers had touched on the association of syphilis with such tumours. Cornil and Ranvier found several cases of the kind were associated with a syphilitic history.

He next showed a specimen of Glandular Cystic Adeno-carcinoma of Ovaries and Vermiform Appendix an account of which will appear in our next issue.

The PRESIDENT said he regarded this as being an instance of the type to which he had already referred, namely, of suggesting innocency at first and then subsequently a rather rapid development of malignancy. He had been especially struck by the extreme malignancy of these growths.

Dr. GILES said one point which particularly concerned him was the question of diagnosis, which in this case, was that of fibroids. Carcinoma of the ovary was a condition which was not often diagnosed directly, especially where there was no free fluid present in the abdomen. The presence of free fluid and cachexia in the patient would suggest that it had a malignant element. He had met with four cases of carcinoma of the ovary not associated with any fluid in the abdomen and all were associated with uterine fibroids. In some, the fibroids were comparatively small, but in all operation was undertaken for fibroids, the presence of an ovarian tumour not having been suspected in any one of them. That was perhaps easily understood, inasmuch as those tumours had a comparatively solid consistence, and when there were multiple fibroids the irregularities might equally indicate them with ovarian growths in addition. Where fluid was present, he thought the prognosis was in most cases bad. In other cases carcinoma of the ovary might be attended with a good prognosis. One of the four cases to which he had just alluded had since died of recurrence, but the other three patients were alive and well at the present time, the periods which had so far elapsed since the operation varying from two to three years. Therefore he considered that if the growth was not attended with free fluid, which meant that the growth had not perforated its capsule, the prognosis might be fairly good.

Dr. MACNAUGHTON-JONES said he exhibited the largest carcinoma of one ovary he had ever seen. There was a fibro-adenoma of the other ovary. At the time the patient was reduced in weight to about 5st. She lived six months afterwards and then died of recurrence of the carcinoma in the bowel. Some years afterwards he showed to the Society carcinoma of both ovaries with large carcinomatous masses and fibro-myomata of the uterus co-existing. He quite agreed that the seriousness of those cases depended upon the escape of carcinomatous fluid. In one of the cases to which he had referred the tumour was solid, and the others were of a cystic character, and the prognosis largely depended upon perforation with escape of some of the fluid into the peritoneal cavity. But on the other hand, he considered that, as a rule, cases of malignant growth of the ovary would be found to terminate fatally.

Dr. MACAN pointed out how often malignant diseases of the ovary were bilateral. All would agree that the occurrence of ascites with any tumour of the ovary pointed to an unfavourable prognosis, and this was especially so when tumours were found on both sides. He had recently the opportunity of looking at the very valuable work of Professor Winter's on diagnosis, and that authority laid great stress on the fact that in malignant disease of the ovaries one was apt to find that both ovaries were affected more or less, though not necessarily to an equal degree.

Dr. E. A. NEATBY said he wished to know whether carcinoma of the ovary occurred frequently as a primary condition. Mr. Bland-Sutton, Dr. Cuthbert Lockyer, and others had recently pointed out how often they occurred secondarily to either some intestinal or some mammary growth. A few months ago he removed a large ovarian carcinoma, and at the same time he found a nodule in the small intestine which he took to be carcinoma, but which he did not consider advisable to remove. He warned the friends that she would probably have to come back for operation later on, and when she returned some months later she was then so weak that she died before operation could be undertaken. Post-mortem it was found that the growth in the small intestine was columnar-celled carcinoma, very much resembling in character that which was found in the ovary. He would be glad to hear what the experience of members had been in that regard, as to the frequency of such growths of a secondary nature in the ovary.

Dr. SWANTON, in reply, said there was no evidence at that time of operation of perforation of the capsule of the cyst, although it might possibly have occurred at a previous date. He diagnosed fibroid growth because the uterus was increased in size and, moreover, was adherent to the mass behind in the pouch of Douglas. His own experience had also been that bilateral malignant disease of the ovarian tissue was more frequent than unilateral disease of that region. He thought his case must have been one of primary carcinoma, because there was no evidence in the abdomen of any other growths beyond that which was shown under the microscope, which occurred in the vermiform appendix. It seemed to him the cystic condition had existed some time previously, and only recently malignant degeneration had come on. The statistics of the frequency of primary ovarian carcinoma showed it to be rather more common than secondary carcinoma.

A MYOMA OF UNUSUAL INTEREST.

Dr. H. **Macnaughton-Jones** showed a large myoma removed from a patient, æt. 32, unmarried. There had been, comparatively speaking, few symptoms, the only one of importance being menorrhagia and consequent anæmia. On exposure of this tumour he had found it quite encapsuled with peritoneum. This was subsequently explained by Dr. Cuthbert Lockyer's report on it, as he says: "The growth arose in the right side of the body and cervix, and has burrowed beneath the peritoneum of the floor of the pelvis." Another peculiar histological feature was the presence of a sacular cavity or long cul-de-sac, which he thought was the dilated and thinned out uterine body which had degenerated. On subsequent examination this was found to have collapsed and the uterus was seen to be incorporated with the tumour. Dr. Lockyer regards this cul-de-sac as a dilated lymphatic, and has found this deceptive resemblance to a uterine cavity on previous occasions. Both ovaries were removed, having degenerated, and lutein hæmatomatous cysts being present.

Professor J. W. **Taylor** asked whether Dr. Macnaughton-Jones did not think the cavity could be accounted for by the separation of the layers of the peritoneum. Sometimes when a fibroid grew into the broad ligament on one side of the uterus he had found the peritoneum separated and the growth more or less encapsulated, a triangular space was formed either above or below the tumour.

The **President** thought that whenever we met with a case of myoma of the uterus there was always some interesting point which was worth discussing. The interesting points about the present one appeared to be the complete capsule, and the small cavity which was formed. He was inclined to agree with the suggestion that it was a simple matter for some inflammatory material to have separated the two layers of peritoneum and formed a sort of false sac.

Dr. **Macnaughton-Jones**, in reply, said Dr. Cuthbert Lockyer's opinion was that the cavity was a lymphatic sac.

Dr. **Swanton** read notes of a case of Cyst of Clitoris, which will be found on page 90.

The **President** thought such cases must be exceedingly rare, although cysts occurred in various parts of the vagina, and often proved troublesome. From the description it did not seem to present any indications of malignant outgrowth.

Professor **Taylor** thought the situation of the growth was unusual. As far as one could judge, it seemed to be of a sebaceous character. He had met with a sebaceous cyst very much like that, but not occurring in the clitoris; it was in the labium minus of one side. He regarded the specimen as a suppurating sebaceous cyst.

Dr. **Macan** said that cysts of that character in the clitoris were very rare. He could not remember any cases recorded in literature. Professor Taylor's explanation of the present case seemed to be the most likely, that it probably arose from sebaceous glands. But in the absence of microscopical details he did not see how the matter could be decided.

Dr. **Swanton**, in reply, said his difficulty in giving further information about the cyst arose from the fact that such a length of time elapsed between the first appearance of the growth and the time at which the operation was performed. The evidence indicated that it was a sebaceous cyst which had suppurated.

THE PRESIDENT'S VALEDICTORY ADDRESS.

The **President** announced that he had received letters of apology for absence from several of the Fellows.

Professor J. W. **Taylor** said he had much pleasure in proposing that the best thanks of the Society be accorded to the President for his Valedictory Address. He hoped it would not be regarded by the President as one of the least of the many honours he had possessed that it was under his presidency that the Society made a great step forward by the junction with its sister organisation, the Obstetrical Society of London in the new Royal Society of Medicine.

Dr. H. **Macnaughton-Jones** had much pleasure in seconding the vote of thanks proposed by Professor Taylor, and would refer to the Minutes of the Council of the Society as to its origin. Those Minutes were interesting from an historical aspect and recorded that: "Several members of the profession specially practising gynæcology considering the time was ripe for the formation of a Gynæcological Society, seeing the question had been omitted for some years past, agreed to meet together to consult and see if such was feasible, and, accordingly, on Monday, December 22nd, 1884, the following met at 27 George Street, Hanover Square: Dr. Meadows, Dr. Robert Barnes, Dr. Aveling, Dr. Bantock, Dr. Heywood Smith, Dr. Fancourt Barnes, Dr. Edis. Dr. Meadows took the chair, and after some remarks from him, Dr. Heywood Smith read letters which had been received from several who had been in favour of the project, and it was agreed to call a meeting of medical men for Saturday, December 27th, 1884, at the rooms of the Medical Society by means of the following circular, of which he would only read one Clause: "Owing to the extraordinary neglect of gynæcology in the general hospitals and their conspicuously inadequate provision of beds for the treatment of diseases of women, special hospitals entirely devoted to gynæcological work have been established." There had been 201 meetings of the Society, and 213 or 215 meetings of its council. He wished to mention the names of Dr. Meadows, Dr. Bantock, Dr. Fancourt Barnes, Lawson Tait, Dr. Charles Routh, Dr. Macan, Greig Smith, Dr. Edis, and Dr. Bedford Fenwick, because they were the names of the men who in the early years of the society had borne the burden and heat of the day. But he also thought that anyone who spoke at the last meeting of the society should acknowledge fully the debt which the society owed to its provincial Fellows. (Hear, hear.) Wherever one might look, in England, abroad, or in the Colonies, we found provincial Fellows of this Society among the most distinguished. One of them was present that evening, a gentleman who not only had been President of the Society, but for whom the Fellows entertained great respect, Professor Taylor. The Society was not the first medical body to admit women to their meetings. Perhaps he might be allowed to say it was the only blot on the escutcheon of the Society that they did not welcome women before they did. But he felt certain that the action of the Obstetrical Society of London in the matter was taken largely because they knew the Gynæcological Society intended doing it. They were glad and proud that it was a provincial Fellow of Mr. Spanton's standing and eminence who occupied the chair of the Society at its dissolution.

The resolution was then carried by acclamation.

The **President** expressed his deep obligation to Professor Taylor and Dr. Macnaughton-Jones for the words in which they had respectively proposed and seconded the resolution, and to the meeting for passing it.

Dr. **Heywood Smith** said they would not be able to separate happily unless they passed a special vote of thanks to one who had really borne the brunt of the whole difficult negotiations which led to the amalgamation, namely, Dr. Macnaughton-Jones. They were justified in congratulating themselves on the work which the Society had done.

Dr. **Richard Smith** seconded the vote of thanks to Dr. Macnaughton-Jones and those who had been associated with him in the work with great pleasure, for the negotiations had an harmonious ending. He was present on one occasion when Mr. Erichsen said at University College that he thought they had arrived at finality in surgery. But what would he have thought now? They all rejoiced in the progress which had been made, and trusted that the future might be even more productive than the past.

The resolution was then put and carried by acclamation.

Dr. Macnaughton-Jones, in acknowledging the vote of thanks, said that it would be more suitable that he should thank the Society for all the help which had been given to him rather than that it should thank him for what he had done to bring about amalgamation. The first President of the Section would be the present President of the Obstetrical Society of London for the time being, Dr. Herbert Spencer. The Fellows of the Obstetrical Society who would form part of the Council would be Dr. Henry Russell Andrews, Dr. Henry Briggs, Dr. Champneys, Dr. Cullingworth, Dr. Dakin, Dr. G. Eastes, Dr. Fairbairn, Dr. Gow, Dr. Handfield Jones, Dr. Herman, Dr. Kerr, Dr. Lewers, Dr. Cuthbert Lockyer, Dr. John Phillips, Dr. Amand Routh, Mrs. Mary Scharlieb, Dr. Herbert Williamson, Dr. Thomas Wilson, with Dr. Robert Boxall as one of the Secretaries. As was understood, each Fellow of the present Society would be a Member of the new Section of the Royal Society of Medicine. It would be seen that the laws which were drawn up were founded upon the general principle of the new Royal Society of Medicine, which was a thoroughly democratic principle.

Dr. Macan proposed: "That we desire to record our appreciation of the courtesy and cordiality with which the Obstetrical Society of London has united with our Society in their arrangements for amalgamation." He believed it was clear that the members of the Obstetrical Society had treated the Fellows of the Gynæcological Society with the greatest consideration and an appreciation of that attitude should be put upon record.

Dr. Slimon seconded the resolution, and it was carried unanimously.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, July 21st, 1907.

Extra-Uterine Pregnancy.

The diagnosis of extra-uterine pregnancy constitutes, in certain cases, one of the most difficult problems of obstetrics. It must be made in the first and second periods of the pregnancy.

During the first months, there exists no certain sign that the woman is pregnant, and the presence of ectopic pregnancy can only be suspected from the history of the case, symptoms of probability, bloody discharge, pain, the presence of a tumour lying against the uterus which has not the volume of the age of the gestation and whose cavity is empty. However, nothing can be affirmed, and the pregnancy might be confounded with: A uterine fibroma, hydro-salpingitis, hemato-salpynx, retro-uterine hæmatocele, retro-version of the gravid uterus, abortion.

A fibroma is intimately connected with the uterus of which it is a direct prolongation; it is not sensitive to pressure and palpation. Metrorrhagia is abundant and painless; its development is slow; the cervix is not spongy to the touch. In certain cases, the diagnosis is impossible.

In the different forms of salpingitis, the distinction is equally difficult. In the research of the causes, it may be possible to establish the existence of an anterior genital infection: Gonorrhœa, abortion, tuberculosis, syphilis. The pain is seated in one of the iliac fossæ or in both, extends down the thighs and is relieved by rest. The menses are painful with more or less violent colic; they are irregular and frequently hæmorrhagic.

To the touch, the os appears healthy or is the seat of metritis; the body of the uterus is increased and painful, while the posterior and lateral culs-de-sac are filled by the inflamed organs. On the other hand, women suffering from salpingitis present a special facies; they are pale, emaciated, dyspeptic, and neurasthenic.

In the majority of the cases of hæmatocele, the rupture of an extra-uterine pregnancy is the cause; sudden and intense pain in the abdomen, signs of internal hæmorrhage, tendency to syncope; later, the presence of a more or less voluminous tumour, at first fluctuating, afterwards becoming hard and resisting; the cervix is pushed forward and applied behind the symphisis of the pubis.

In retro-version of the gravid uterus, the os presents the normal sponginess, and bi-manual examination proves that the uterus alone is increased in volume, and if the tumour can be reduced there is no doubt possible as to the existence of a normal pregnancy.

During the last months of ectopic pregnancy, the diagnosis becomes singularly easy. The fœtal cyst becomes more evident and can be easily felt on one of the sides of the median line. By auscultation the movements of the fœtus can be perceived as well as the bruit de souffle and the heart beats. Where the fœtus is dead the difficulties of diagnosis are increased. In such case, diverse questions put to patient may throw light on the nature of the tumour; if there existed symptoms of abortive labour, if membranes were expelled, if the breasts had increased in volume, if the volume of the abdomen had diminished, &c. In practising several successive examinations, the attendant will be able to satisfy himself if the tumour is in way of regression, if there exists osseous crepitation, a sign of great importance when established.

The prognosis is almost always fatal for the child and very grave for the mother.

As to treatment, extra-uterine pregnancy should be considered, said Woerth, as a malignant tumour, and requires extirpation as soon as it is diagnosed, while other authors advise expectancy where the pregnancy has reached beyond five months, and that the fœtus is alive. But the patient should be constantly watched so that an operation could be made at the first signal.

Where the fœtus is dead, and if there are no bad symptoms, the operation may be deferred until the hæmorrhage is less abundant by reason of the decrease of the cysto-placental circulation.

Acute Rheumatism and the Thyroid Gland.

There seems to be a correlation between the thyroid gland and the articular inflammation of rheumatism. M. Vincent reports several cases of acute articular rheumatism, where the thyroid gland was increased in volume and very painful to pressure. Sometimes, on the other hand, the gland is hardly perceptible to inspection or palpation, but in those cases the rheumatic fever runs an ordinary course. In other patients, after a temporary reaction of the thyroid gland, it diminishes considerably in volume, while the articular symptoms persist. Improvement is slow, and the malady leaves the patient in a state of anæmia and prostration.

GERMANY.

Berlin, July 21st, 1907.

At the Medizinische Gesellschaft, Hr. Westenhoeffer showed lymphatic tumours of the stomach and intestines from a patient who had died from leucæmia. The tumours were in part ulcerated, from which fatal hæmorrhage had taken place.

Hr. Ernst Mai reported on Escarine lately recommended by G. Klemperer for hæmorrhage from the stomach. Ten cases had been treated by it in the Moabit Hospital. In all of them the bleeding stopped at once, so that the day after no blood was found even in the stools, although milk and eggs had been given on the first day, whilst the former custom in the department had been not to give patients with bleeding from gastric ulcer any food by the mouth for the first three days.

Out of the ten cases the bleeding returned in one only, and the case proved fatal. The autopsy showed carcinoma. Escarine was a mixture of the finest aluminium powder in glycerine. It was prepared for sale in tablet form, in tubes with six tablets each, of 2.5 grm. each, of which four to five tablets were given stirred in water. This dose was given two days consecutively. It was cheaper than the continued use of bismuth powder. He had given the remedy to rabbits and dogs in which an abrasion of the mucous membrane had been caused by a wound, and on the animals being killed the mixture was found to be well spread over the wounded surface.

Hr. Ewald, although he had given large doses of bismuth for long periods, had never seen any symptoms of poisoning from it. He had also tried escarine and had seen good results from it; it did not always do good however; thus in one case he had given it for three consecutive days, but the bleeding steadily returned in spite of it, and only ceased after gastro-enterostomy.

Hr. Niemann read a paper on

The Practical Results of the Feeding of Infants with Buttermilk.

He first of all emphasized the fact that only perfectly fresh buttermilk made in large establishments came into consideration. As an addition, 15 grm. of wheatmeal and 60 grm. of sugar were added to each litre of buttermilk. These were shredded in under continuous stirring, the mixture was boiled for a short time, and then kept cool; 120 infants were fed with it, 102 with a good result. Very little children, and those above æt. 8 months, were not suited for this form of feeding.

Twenty-six healthy children, who had not thriven well on a diet partly of cow's milk, did excellently on this. Of 71 children with intestinal catarrh, 63 bore the buttermilk diet well; but it must not be given too early, not until the third day, when the acute symptoms had subsided. The combination acted well especially in children who were much run down after intestinal catarrh or were otherwise atrophic. If a greater proportion of fat was desired, cream could be added. By means of a large series of curves the influence of buttermilk on the increase of weight was shown, and, in conclusion, he observed that any early repugnance was soon overcome, and no vomiting took place, but the bowels required regular watching; the stools were mostly alkaline, but acid in about 28 per cent. Not unfrequently, on commencing with the buttermilk diet, a slight increase of temperature was observed; if this remained or got higher the diet had to be changed.

Hr. Cassel believed that with healthy children the buttermilk diet could be given from the first; it was also well adapted for mixed feeding; its proper domain, however, was in intestinal catarrh after the acute stage had subsided, and in atrophic children. The difficulty to the general introduction of buttermilk feeding lay in its very precise technique, and the great watchfulness required. Soxhlet's feeding sugar might be given in place of sugar. It was best to begin with small doses and increase them very gradually. The stool reaction was of no importance, but if vomiting occurred, if the stools were frequent and squirty, if the abdomen was distended and tender, the diet must be changed at once. If at first there was repugnance to the food it might be overcome by giving it by the spoon and cold. There was sometimes a difficulty in weaning from buttermilk; this was assisted by an addition of cream or 3 to 5 per cent. of ramogen, then passing on to half-milk or two-thirds milk. It was not correct that rickets came on more frequently with buttermilk feeding than otherwise. Its chief advantage lay in its poorness in fats and in its purity.

Hr. Jaffa remarked that buttermilk feeding had its distinct indications; it was suited for all children who could not bear fats; on the other hand its richness in sugar prevented its being well borne by all children.

AUSTRIA.

Vienna, July 21st, 1907.

Simulated Monoplegia.

Erben showed a case of monoplegia, which gave rise to a long controversy on the physiology and anatomy of the limbs. Erben wished to prove to the members by his mode of examination that paralysis was not real, but Tandler disputed the case.

Tandler said, if a man were laid prone, and his knee bent up to a right angle on the leg, and then allowed to fall, it would descend in the normal direction by the action of the quadriceps, viz., rectus, vastus, externus, and internus, and crureus. If the lower part of the leg be bent past this right angle towards the body when in the same position, the leg would fall towards the body in paralysis, but he doubted if the first experiment was due to the contraction of the quadriceps. If a perfectly healthy man be tried in this way over the right angle the leg will violently assume the stretched position. For part of the first movement he admitted that the tonus of the quadriceps governed the movement in the healthy subject, but in the dead body there was none.

At this point Reiner presented a case of bilateral quadriceps paralysis, the result of polio-myelitis seven years ago. Tandler's phenomena were clearly demonstrated. The peculiarity of both muscles being similarly affected was a source of surprise, as the cells in both of the anterior cornua must have suffered. It was also proved by this case that the quadriceps could be dispensed with in standing erect, which the patient could do admirably; but when he attempted to walk the defect was instantly observed, by the tension of the plantar muscles and the stamping character in motion. In coming down stairs he substituted the action of the quadriceps by swinging round the descending foot with the point of the foot outstretched to reach the lower step, while the opposite side swung round to perform the next step, which resembled talipes equinus in extension.

With this patient, Erben performed his method, which Tandler objected to, all proving how paralysis can be simulated; after which Tandler admitted that Erben had some foundation for his proof, but had changed his position since demonstrating his own case.

Thrombosis Arteria Vertebralis.

Algyogyi presented a case with symptoms he would place before the members for their judgment: Right eyelids and pupil narrower than left, reaction prompt, right bulbus more sunken, movement to both sides free, no double vision, slight nystagmus in lateral vision, fundus in both normal, sensory and motor function of trigeminus normal, slight insufficiency of the muscles of the lips on right side, pronounced in laughing; uvula tense, with smell, taste, and hearing intact.

There was decided hoarseness in consequence of paralysis of the right vocal cord; but no real cause could be discovered. Motility in limbs free, but slight adynamia of the right arm and hand was present.

Sensibility on right side normal, particularly in the region of the trigeminus, but the left in this part was markedly dull; Faradic pain, and temperature quite lost. This defect extended below the fourth cervical vertebra, and extended round the trunk. There was no ataxy or Romberg symptom present. The thoracic organs, with the exception of the second aortic tone, perfectly normal, and the same might be said of the abdomen.

Pulse 85, right patellar reflex too high, plantar reflex absent on left side but normal on right. Abdominal reflex increased on right; radius right increased. Reflex of palate and pharynx gone, while that of conjunctiva and cornea was present.

Weight before illness, 82, kilos; now 78. Urine gave 5.2 per cent. of sugar; other constituents normal, but with specific diet the sugar fell to 0.1 per cent.

From these symptoms the medulla oblongata would be accused as the centre, and probably the right half, which might be acute or apoplectic bulbar paralysis. From the symptoms it would seem that the vascular system is at fault somewhere, and as hæmorrhage into the oblongata is a rare occurrence and usually associated with violent symptoms, loss of conscience and a speedy termination, which were absent in this case, we must fall back on the more progressive lesion of a partial thrombus in the vertebral artery.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Centenary of the Edinburgh Royal Asylum.—The hundredth anniversary of the foundation of Morningside Asylum was commemorated on July 12th by a garden-party held in the Institution, which was attended by some fifteen hundred guests. Happily the weather was propitious, and the function passed off successfully. The whole of the grounds and most of the buildings were available for the purposes of the function, and the quaint sixteenth century architecture of Old Craig House, once the residence of John Hill Burton, the Scottish historian, was viewed with special interest. A mass of the buildings and grounds enabled the guests to find their way unaided to points of special interest, including Criaglockhart Hill, which is 500 ft. above sea level and commands a magnificent view of the town and surrounding country. The awakening of Edinburgh to the need for some means of caring for the insane is associated with the death of the Poet Fergusson in 1774. Fergusson was one from whom Burns drew some of his inspiration; he became insane and died amid squalid surroundings in the old city Bedlam. The sad circumstances attending his death aroused the compassion of some of the more public-minded citizens, foremost among whom was Dr. Andrew Duncan, Senior, one of the leading philanthropists of the day, and one to whom Edinburgh owes more charities than the Royal Asylum. He circulated a pamphlet proposing the establishment of a lunatic asylum, being at the time President of the College of Physicians, but, though some support was secured for the project, immediate succour was not attained. Later, a Parliamentary grant of £2,000, drawn from the estates forfeited by Jacobites in the '15 and '45 ("one good result of rebellion," the History of the Asylum has it) was obtained, and a Royal Charter was granted in April, 1807. The asylum was actually opened for patients on July 19th, 1813, and the structure thus initiated served until 1837. Accommodation was offered only to those who had means, and in that year the claims of the indigent insane were at last recognized as so strong that the institution was extended to meet the case of those who could pay nothing, or little, for admission. In 1877, the whole institution was reorganised. Dr. Clouston, who succeeded Dr. Skae in 1873, took a leading part in this. He visited the chief asylums in America and on the Continent, and the reconstruction was carried out along the lines suggested by this visit. West House was almost entirely rebuilt and the East House was temporarily enlarged pending the completion of the buildings on the Craig House estate, purchased about that time. Old Craig House was retained in its original form as an old mansion house, while the new buildings were scattered about the grounds in the form of villa residences. During the past 90 years, £370,000 has been spent on land and buildings; of this amount £284,100 has been paid off. The income from private patients has risen from £12,000 to £38,000, and the staff now numbers 269 persons. Since its reconstruction the asylum has taken a creditable place among the public institutions of Edinburgh, and has maintained a reputation as being in the van of medical science.

Royal Visit to Edinburgh.—Their Royal Highnesses the Prince and Princess of Wales paid a visit to Edinburgh last week in order to fulfil several public engagements. On July 11th, they made a brief tour of inspection of the Royal Infirmary, where they were received by the Lord Provost, Colonel Warburton (Superintendent), Mr. Caw (Treasurer), and Miss Gill (Superintendent of Nurses). In the outer hall the Board of Managers, and in the inner hall members of the medical and surgical staffs, including Drs. Greenfield, Bramwell, Bruce, Russell, Grelland, Graham Brown, Fleming, Ritchie, and Rainy, and Messrs. Annandale, Chiene, Macgillwray, George Mackay, Cathcart, Paterson, and Guy were presented to the Prince and Princess. The Royal Party then proceeded to the Diamond Jubilee Pavilion, and visited Ward 35, in which gynæcological cases are treated. Dr. Barbour, the physician-in-charge, and Drs. Fordyce and Haullan, assistant physicians, were present and accompanied their Royal Highnesses round the ward. The Prince of Wales, in conversation with Colonel Warburton, asked many questions regarding the expenditure of the institution, and treatment and feeding of the patients, and indicated that for economical management the Infirmary compared favourably with other institutions of which he had personal knowledge. After going through the wards and operating theatre the Royal party visited the lower corridor in order to see the dedicatory memorial tablet, with the appearance of which they expressed gratification. The visit was a comparatively short one, lasting only some thirty minutes, and at its close the Prince and Princess expressed themselves as highly satisfied with the brightness and airiness of the Infirmary, and much impressed by its extent.

Compliment to Sir A. R. Simpson.—On July 15th, a complimentary ceremony took place in the Edinburgh Royal Maternity Hospital, the Committee who had undertaken the duty of making some recognition of Sir A. R. Simpson's long and distinguished career, meeting the Board of Directors there, and asking their acceptance of a gift of money towards the endowment of a bed. Mr. Nicholson, on handing over the cheque, said that the Committee thought the object they had in view of showing their appreciation of Sir Alex. Simpson, could best be attained by endowing a bed in the institution in which he had always taken so lively an interest, and which bore the name of his uncle, Sir James Young Simpson. The Chairman of the Board thanked the Committee and said he considered it a high honour to the hospital to have such a permanent memorial of Sir Alexander Simpson.

LETTERS TO THE EDITOR.

ENGLAND AND GERMANY—A CONTRAST.

To the Editor of The Medical Press and Circular.

Sir,—Your correspondent "M. O. H." in his letter of July 10th, asks whether English local government, judged by results, is a failure? No one who knows enough about German methods can fail to answer this query in the affirmative. Germany, under a scientifically-guided bureaucracy, is making immense strides. Her people, as a whole, stand on a higher plane of civilisation than ours. They are better educated, and have more self-respect. Ragged vagabonds, unemployables are as difficult to discover as the class of 'Arry and 'Arriett. I have never met anyone who has ever encountered a drunken woman in Germany. The people are profoundly discontented with their Government in the region of higher politics, but understand and recognise the necessity of obedience and co-operation in matters affecting social progress. They are, for example, all vaccinated and re-vaccinated, so that small-pox is virtually extinct, and they are ready to obey any evidently beneficial police order, however trivial, down to the cropping of their children's hair. School children for years have all been systematically inspected medically, and sorted and dealt with in accordance with physical and mental standards. The three years' military service leaves a highly beneficial mark on the bulk of the young manhood, and almost completely prevents the manufacture of the hooligan class. The condition of the homes of the working men and poor everywhere, including the big towns where the housing problem is acute, is, on the whole, very superior to that common in England. This fact was dwelt upon in the remarkable report of the Birmingham brass-workers after their full enquiry in Berlin. In England sanitary laws are almost everywhere imperfectly administered for the reason which "M. O. H." points out, namely, that the mass of citizens are too selfish and indifferent to take a due share in local Government. Local governing bodies are everywhere too largely made up of ignorant or selfish men, and these, through lack of local public opinion, neglect the laws it is their duty to administer. An essay would be needed to expose fully the contrast between the two peoples in every social phase. Germany has in the Fatherland almost ten millions more people than the total population of European blood in the whole British Empire, and is increasing at the rate of nearly a million a year. Unless the teaching of history is worthless, the expansion of this mighty race should convey a warning and a lesson to patriotic Englishmen and the statesmen by whom they are guided and led.

I am, Sir, yours truly,
A Student of Sociology.

July 19th, 1907.

QUACK DENTISTS AND A ROYAL COMMISSION.

To the Editor of The Medical Press and Circular.

Sir,—I notice that the quack dentists affect great indignation at the suggestion that a Royal Commission on Quackery should include them in its scope. The dental speciality is a legally recognised branch of the medical profession, and under the same administration —the Medical Council—and could not be left out of the enquiry. One would have thought that unqualified men, if they had any justification for their position, would have welcomed investigation, and even personal cross-examination as to their methods by leading counsel. They will be liable to be subpœnaed and compelled to give evidence. If, as there need be no doubt, a Commission should be in due course appointed, we shall then, at least, have a full public exposure of what is now dark in this direction.

I am, sir, yours truly,
A Hospital Dentist.

July 18th, 1907.

OBITUARY.

DR. ALFRED LLOYD OWEN, M.D., OF SOUTHSEA.

We greatly regret to record the death of Dr. Lloyd Owen, of Southsea, on the 4th inst., which sad and unexpected event has deprived a large circle of friends of a greatly valued adviser, and his professional brethren also of a wise, experienced, and much-esteemed colleague.

Lloyd Owen was born at Portsmouth in August, 1845, and he was the third son of Mr. Jeremiah Owen, who then held a high and important position in the Royal Dockyard. He was educated at Christ's Hospital and on leaving the school he went to Trinity College, Dublin, and there passed through a distinguished career as a student. In 1866, he obtained the degrees of B.A. and M.B.Dublin, and also the diploma of M.R.C.S.Eng. After a short absence he returned to Trinity College, and took the degree of M.D. He was appointed house surgeon to the Royal Free Hospital, London, in 1867. In 1869 he married the daughter of the late Dr. William Gibney, surgeon of the 15th Hussars, and soon after entered into partnership with the late Mr. Husband, of York, the senior surgeon of York County Hospital, and treasurer of the British Medical Association. He did not remain, however, long in Yorkshire, for in 1870 he commenced practice in Southsea—formerly only a suburb of Portsmouth, but at this period it had become a fashionable resort which was largely due to the skill and enterprise of Dr. Lloyd Owen's uncle, Mr. Thomas Owen, who for several years was Mayor of Portsmouth, and occupied a leading position in the neighbourhood.

By his natural ability, unflagging industry, and extreme courtesy, Dr. Lloyd Owen soon obtained a high professional reputation and an extensive practice. He held the appointment of surgeon on the staff of the Royal Portsmouth Hospital for 35 years with great distinction, and on his retirement in 1906 he received the warm and hearty thanks of the Committee of Management, and was elected consulting surgeon to the hospital. During this long period his services were greatly appreciated by the suffering poor, and he did much to help forward the progress and development of the Institution. For many years he also held the important post of Admiralty surgeon at Portsmouth.

As a surgeon, Lloyd Owen's career was very successful. He was an excellent practitioner, painstaking in the discharge of every duty, and enjoyed to a remarkable extent public confidence and esteem. Of his qualities of head and heart no one could speak too highly. The writer of these few lines had for years many opportunities of estimating his character. Personally, he was a true and faithful friend, with a transparent integrity and courtesy visible in every action. A striking example of his kindness of heart was exhibited during his last illness by his anxiety to secure a grant of money from the surgical aid fund of the hospital to help a poor girl, whose limb he had removed, in obtaining an artificial limb.

In his home life he was a devoted husband and father, and now the deep sympathy of all who knew him is with his widow and her family in their sudden and irreparable loss and sorrow.

Dr. Lloyd leaves behind him five sons and one daughter. Two of his sons are officers in the Royal Navy, and two are serving in the Army.

The funeral took place at Southsea on the 8th inst. with universal expressions of regret, and around his grave there was a great gathering of old friends and colleagues, who were present to pay a last tribute to one whose memory will ever be associated with the warmest and kindest recollections.

J. W. C.

DR. JAMES DUNSMURE, OF EDINBURGH.

Much regret, as well as surprise, was felt in Edinburgh on hearing the sad news of the unexpected death of Dr. Dunsmure, which took place on July 15th. Some weeks ago he underwent an operation, and apparently rallied from it, but on the 15th, he had a relapse and died very suddenly from heart failure. Dr. Dunsmure came of a medical stock, his father, like himself, having been one of the best-known practitioners in Edinburgh. He was educated at Edinburgh, and studied in Berlin and Vienna, and on his return home succeeded to his father's practice and to many of the appointments his father held. Then he became medical adviser to the Governors of Trinity Hospital, the Alexander Mortification, John Watson's Institution, the Trades Maiden Hospital, and the N.B. Railway Company. Like his father, he was a President of the Royal College of Surgeons of Edinburgh, and took a keen interest in the Quarter Centenary celebration of a few years back. During his term as President, he had the honorary degree of LL.D. conferred on him by the University of Glasgow. He was a keen sportsman, and delighted in shooting, fishing, and golf; along with three friends he made a point of playing a weekly foursome at Musselburgh Dr. Dunsmure was of a somewhat retiring disposition, but was a kind-hearted genial man, and had few equals either as companion or host. He was a widower, and is survived by his only daughter.

J. S. F.

FRANCIS HYDE FORSHALL, M.R.C.P.Ed., M.R.C.S., L.R.C.P.

We regret to announce the death of Dr. Francis Hyde Forshall, which occurred on July 6th, at Highgate, in his seventy-fourth year. Dr. Forshall was the youngest son of the late Rev. Josiah Forshall, F.R.S., formerly Secretary and Keeper of the Manuscripts at the British Museum. He was educated at Tonbridge School, Edinburgh University, and St. Bartholomew's Hospital. When he was qualified as L.R.C.P., he joined the Medical Department of the Army, in which he remained about seven years, seeing service in India and Canada. After leaving the Army he studied in Paris for a time, and then went to Highgate, where he entered into partnership with the late Dr. Harrison. He held several public appointments during his active life, including the

Police Surgency to the Y Division and the medical officership of the Highgate and Muswell Hill Dispensary. Dr. Forshall retired from practice sixteen years ago, and was then presented with some very beautiful silver of the George II. period, valued at £300, and an illuminated address.

REVIEWS OF BOOKS.

PHYSICAL DIAGNOSIS. (*a*)

THIS volume forms an excellent handbook of physical diagnosis. In spite of the many admirable works in existence dealing with that subject, the author may be congratulated on having added to the number another having various praiseworthy and peculiar features. The accuracy of the matter is maintained at a high and consistent level. The work being confined to some 450 pages, the author has wisely contented himself with dealing fully with more important sections, such as the application of systematic methods of physical examination to the thorax, heart and pericardium, and the abdomen. Many points are in this way necessarily either omitted or dealt with briefly. For instance, we find no mention of exophthalmos, nor of exophthalmic "goitre" beyond a casual reference to the visible pulsation often present in that condition. On the whole, however, Dr. Anders may be congratulated on the brilliant way in which he has performed his task, although the American methods of spelling will jar the susceptibilities of educated English readers. There are many excellent diagrams and other illustrations, but most noteworthy of all is the fine series of plates illustrating the Röntgen-ray diagnosis of various thoracic and abdominal conditions. One illustrating the intestinal contents is specially interesting.

DISEASES OF THE EYE. (*b*)

THE author, in his book, has set himself the task of writing a concise description of the commoner eye diseases, designed solely to meet the needs of the physician engaged in general practice, rather than a complete treatise on eye disease. Remembering that a "little knowledge is dangerous," Dr. Theobald does not encourage his readers to trust to such methods as ophthalmology, retinoscopy, or perimetry as an aid to diagnosis, unless they have opportunities of considerable practice in perfecting themselves in these arts. Such methods of examination as oblique illumination and the perimeter are well described and in the case of the latter sufficiently fully for ordinary purposes. We like the way Dr. Theobald lays down his treatment of the various diseases. Instead of enumerating several remedies which *might* cure, and leaving it to the inexperienced reader to take his choice, he lays down one or two courses which his experience has taught him to be usually efficient. The appendix contains a useful list of prescriptions with a short note as to the indications of each, which will be welcome to many; and although there is nothing original in the book, nothing, in fact, that cannot be found in existing authorities, the author has been, on the whole, successful in being simple and precise in his descriptions of prevalent diseases and their treatment.

NEW BOOKS AND NEW EDITIONS.

THE following have been received for review since the publication of our last monthly list:—

SIDNEY APPLETON (London).
The Principles and Practice of Dermatology. By Wm. A. Pusey, A.M., M.D. Illustrated. Pp. 1,021. Price 25s. net.

JOHN BALE, SONS AND DANIELSSOHN, LTD. (London).
The Haslemere Museum Gazette. Conducted by Jonathan Hutchinson, F.R.C.S., LL.D., F.R.S., assisted by E. W. Swanton. Vol. I., 1906 and 1907. Pp. 622. Price 7s. net.

BAILLIERE, TINDALL AND COX (London).
The Office of Midwife (in England and Wales). By Stanley B. Atkinson, M.A., LL.M., M.B., etc. Pp. 123. Price 2s. 6d. net.

BURGIS AND COLBOURNE, LTD. (Leamington Spa).
Royal Leamington Spa: Its Springs, Baths, and General Attractions. By John Murray Moore, M.D., M.R.C.S., etc. Pp. 34. Price 3d.

CASSELL AND CO., LTD. (London).
Billharziosis. By Frank Cole Madden, M.D., F.R.C.S. Pp. 78. Price 3s. 6d. net.
Gout: Its Pathology Forms, Diagnosis, and Treatment. By Arthur P. Luff, M.D., B.Sc., F.R.C.P. Third Edition. Pp. 290. Price 10s. 6d. net.

THE CLARENDON PRESS (Oxford).
Surgical Instruments in Greek and Roman Times. By John Stewart Milne, M.A., M.B. Illustrated. Pp. 187.

JAMES CLARKE AND CO. (London)
Health in the Home Life. By Honnor Morten. Pp. 170. Price 1s.

FROWDE, HENRY, Oxford University Press, and HODDER AND STOUGHTON, 20, Warwick Square, London, E.C.
The Oxford Medical Publications. (In the Choice of Authors and Subjects the Publishers have had the Advantage throughout of the Advice and Assistance of William Osler, M.D., F.R.S., Regius Professor of Medicine in the University of Oxford).
Practical Anæsthetics. By H. Edmund G. Boyle, M.R.C.S., L.R.C.P., Assistant Anæsthetist to St. Bartholomew's Hospital. Pp. 178. Price 5s. net.
The Treatment of Disease in Children. By G. A. Sutherland, M.D., F.R.C.P., Physician to Paddington Green Children's Hospital, to the North-West London Hospital, and to the City Orthopædic Hospital. Pp. 311. Price 5s. net.
Surgical Emergencies. By Percy Sargent, M.A., M.B., B.C. Cantab., F.R.C.S., Surgeon to Out-patients, St. Thomas's Hospital. Pp. 256. Price 5s. net.
Medical Lectures and Aphorisms. By Samuel Gee, M.D., F.R.C.P., Honorary Physician to H.R.H. the Prince of Wales and Consulting Physician to St. Bartholomew's Hospital. Second Edition. Pp. 307. Price 5s. net.
Diseases of the Larynx. By Harold Barwell, M.B.Lond., F.R.C.S.Eng., Surgeon for Diseases of Throat, St. George's Hospital. Pp. 266. Price 5s. net.
Functional Nervous Disorders in Childhood. By Leonard G. Guthrie, M.A., M.D., F.R.C.P., Senior Physician to Paddington Green Children's Hospital; Physician to the Hospital for Epilepsy and Paralysis, Maida Vale. Pp. 300. Price 7s. 6d. net.
Cancer of the Womb: Its Symptoms, Diagnosis, Prognosis and Treatment. By Frederick John McCann, M.D.Edin., F.R.C.S. Eng., M.R.C.P.Lond., Physician to In-patients, Samaritan Free Hospital for Women, London; Lecturer on Gynæcology, Medical Graduates' College and Polyclinic, London. Pp. 172. Price 20s. net.
Heart Disease and Thoracic Aneurysm. By F. J. Poynton, M.D., F.R.C.P. Pp. 310. Price 5s. net.
Auscultation and Percussion. By Samuel Gee, M.D., Fifth Edition. Pp. 325. Price 5s. net.
Clinical Lectures and Addresses on Surgery. By C. B. Lockwood. Pp. 276. Price 5s. net.
The Operations of General Practice. By Edred M. Corner, M.A., M.B., etc., and H. Irving Pinches, M.A., M.B., etc. Pp. 296. Price 15s. net.

HENRY J. GLAISHER (London).
On Acute Pneumonia: Its Signs, Symptoms and Treatment. By Seymour Taylor, M.D., F.R.C.P., Physician to the West London Hospital, etc. Pp. 64 Price 1s. net.

WILLIAM HODGE AND CO. (Glasgow).
County Council of Dumbarton: Sixteenth Annual Report (Year 1906) to the County Council and District Committees By John C. M'Vail, M.D., D.P.H., etc. Pp. 103.
County Council of Stirling: Sixteenth Annual Report (Year 1906) to the County Council and District Committees. By John C. M'Vail, M.D., D.P.H., etc. Pp. 160.

LEWIS, H. K. (London).
What to Do in Cases of Poisoning. By William Murrell, M.D., F.R.C.P. Tenth Edition. Pp. 280. Price 3s. 6d.
Post Graduate Clinical Studies for the General Practitioner. By H. Harold Scott, M.B., M.R.C.S., etc. First Series. Pp. 166 and 35 diagrams. Price 8s.

J. B. LIPPINCOTT AND CO. (London).
International Clinics: A Quarterly of Illustrated Clinical Lectures, etc. Edited by W. T. Longcope, M.D. Vol. II. Seventh Series, 1907. Pp. 312.

OBSTETRICAL SOCIETY OF LONDON.
Transactions of the Obstetrical Society of London. Vol. XLIX., for 1907. Part II., for March, April and May. Pp. 206. Price 5s.

YOUNG J. PENTLAND (Edinburgh).
The Edinburgh Medical Journal. Edited by Alexis Thomson, M.D., F.R.C.S.Edin., and Harvey Littlejohn, M.B., F.R.C.S. Edin. New Series. Vol. XXI. Pp 576.
Manual of Surgery. By Alexis Thomson, F.R.C.S.Edin., and Alexander Miles, F.R.C.S.Edin. Vol. II. (Regional Surgery). Second Edition, revised, enlarged and illustrated. Pp. 816. Price 10s. 6d. net.

JOHN WRIGHT AND CO. (Bristol).
The Clinical Use of Prisms. By Ernest E. Maddox, M.D., F.R.C.S.Edin. Fifth Edition, revised and enlarged. Pp. 205. Price 5s. 6d. net.
A Pharmacopœia for Diseases of the Skin. Edited by James Startin. Sixth Edition. Pp. 64. Price 2s. 6d., net.
Through Jamaica with a Kodak. By Alfred Leader. Illustrated. Pp. 208. Price 6s. net.

(*a*) "Physical Diagnosis." With case examples of the inductive method. By Howard Anders, M.D., Professor of Physical Diagnosis. Philadelphia: Sydney Appleton. 1907.

(*b*) "Prevalent Diseases of the Eye." By Samuel Theobald, M.D., Professor of Ophthalmology and Otology in the Johns Hopkins University, U.S.A. Pp. 520, 219 illustrations, and 10 coloured plates. Philadelphia: W. B. Saunders Company. 1906.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT SURGICAL LITERATURE.

The Rôle of the Various Elements in the Development and Regeneration of Bone.—Sir Wm. MacEwen (*Brit. Med. Journ.*, June 22nd, 1907) undertook this inquiry by direct experiment. The subject is dealt with under two heads: (*a*) To test the potentiality of periosteum as a factor in the reproduction of bone. It was found that (1) when a complete cylinder, constituting a portion of the shaft of a long bone, was removed while the periosteum was preserved intact, that ten weeks later an osseous defect was found constituting a gap in the continuity of the shaft; (2) periosteum freed from osseous plaques when removed and transplanted was not followed by reproduction of bone, but by the absorption of periosteum; (3) silver rings were placed on bone deprived of periosteum, with the result that in each case the rings became covered by bone. (*b*) The regeneration of bone, from proliferation of osseous tissue. (4) Direct experiment, showing that a long bone deprived of its periosteum continues to grow; (5) so also do flat bones of the skull; (6) bone may be made to grow in the midst of lacerated muscles by the mechanical distribution of osteoblast; (7) shavings of nude bone placed between muscles in a gap in the continuity of the shaft showed in seven weeks, not only that they grow, but that they also proliferate to a very marked extent; (8) there is direct evidence to show that transplanted living bone actually grows and proliferates, instead of forming, like blood-clot, a passive framework for the granulation tissue to penetrate, which framework will then become absorbed; (9) to test the osteogenetic power of bone cells constituting the shaft of a long bone, they were grown inside of a glass tube. S.

The Use of Massage and Movement in the Treatment of Fractures.—Cathcart (*Scottish Med. and Surg. Journ.*, July, 1907), from personal experience, has come to the following conclusions on this subject (1) Absolute immobility of the broken ends of bone is not essential to bony union. (2) Extravasated blood in joints, and among muscles and synovial sheaths, leads to adhesions in its neighbourhood, apart from the bruising and laceration of soft parts which accompanies fracture. (3) Massage, in the form of stroking and gentle kneading, and with it occasional movements are beneficial in the treatment of fractures, as they aid the actual union of bones, help in the absorption of effused blood and serum, restrain if not prevent the formation of adhesions among the soft parts, and maintain the nutrition of the muscles. They therefore simultaneously hasten union and prepare the limb to return to functional use almost as soon as the bones are united. (4) Splints, extensions, &c., are more to prevent mal-union, than non-union. (5) The manipulation necessary for the massage and movement treatment of fractures can be successfully carried out by anyone who will take the trouble to understand the object of manipulation and is sufficiently gentle to handle the part without causing pain. In recent fractures, massage diminishes swelling, allays muscular spasm, and soothes pain. When there is much pain and spasm of the muscles passing over the broken bone a small hypodermic of morphia or hot fomentations are of advantage. The limb is well dried and dusted with some fine powder to facilitate rubbing. Gentle stroking of the limb should be begun on the proximal side of the injury, the amount of pressure to be used must be guided by the sensations of the patient, as the patient must not be caused any pain. Even when a general anæsthetic is required, preliminary massage should be employed to reduce effusion before splints are applied. As regards movements, active movements will help to prevent stiffness, and passive movements will help to maintain nutrition. Gentle passive movements should be used first. Both forms of movement require to be used with care so as to avoid displacement of the broken ends of bones; and pain and serious discomfort to the patient must always be avoided. There is one form of active movement to which the author calls especial attention, that is in the reduction of displacement due to muscular contraction. Apparently voluntary efforts insure relaxation of the displacing muscles together with contraction of those that are helpful in reducing the deformity. Discussing splints, the author considers that they are useful (1) to prevent deformity, and while pain on movement lasts; (2) to give support to the seat of fracture and adjacent parts. He considers that the long splint for treatment of fracture of the shaft of the femur will seldom now be needed, since we no longer wish to fix the hip and knee-joint, except in restless children and delirious adults, and since we can quite well prevent rotation outwards of the lower fragment by sand-bags. There are cases in which continuous extension by weights or an elastic cord are indispensable to obtain the best possible apposition of broken ends of bones. But the extension should not be continued too long—not after ten days to three weeks. The author discusses the treatment in reference to various common fractures, including fracture of the olecranon and patella. S.

Notes of an Experience of Stovain as a Spinal Analgesia in 100 Cases.—Pringle (*Brit. Med. Journ.* July 6th, 1907), who has been employing this method of producing anæsthesia for operations in Glasgow, used Bier's preparation of stovain with epirenane, as put up by Billon, of Paris, in 98 of his cases; two patients got Chaput's preparation. The injection is made with the patient sitting up and the shoulders arched. There is seldom any pain in connection with the injection, which is best made in the first lumbar space. It is essential to get a free run of cerebro-spinal fluid when the trocar is withdrawn. After the stovain (from .04 to .06 cg.) is injected, the pressure of the cerebro-spinal fluid is, in the majority of patients, sufficiently great to force the syringe plunger back into the barrel, and this is allowed to occur several times to ensure a good mixture of the solution with the fluid. The effects are produced in from five to fifteen minutes. Usually muscular paralysis of the lower limbs is complete before sensation is abolished. Analgesia has, on an average, reached the level of the tenth dorsal nerve. In one case it was complete up to the clavicle on both sides without any respiratory difficulty being induced. The highest incision under stovain was for umbilical hernia. Very few patients manifested any discomfort during the period they were under the influence of the drug. There was a little retching or vomiting in the case of a few, and four patients had syncopal attacks; but in no case was there any anxiety about the condition. The ages of the patients varied from 13 years to 80 years. In two cases unilateral analgesia only occurred. The 100 operation cases included amputations of the thigh (2), hernias (31), appendicitis (12), wiring fractures (6), suprapubic prostatectomy (3), inguinal colostomy (2), pyonephrosis (1), &c. Among these 100 patients there were 22 cases of failure to induce analgesia sufficient to allow the operation to be completed. The after-effects of stovain have not been troublesome at all. Headaches have been complained of by some patients, and one or two have vomited a little after operation; but in neither case were these symptoms as severe as is often seen after ether and chloroform. A good number of patients complain greatly of pain in the wound for the first hour or two after the operation,

more so than after a general anæsthetic. In conclusion, the author has no doubt that in stovain we have a very excellent anæsthetic for the region comprising the lower limbs, and the lower part of the abdomen, even though it may be a little uncertain in its action.
S.

Symptomatic Varicocele in Malignant Tumours of the Kidney.—P. Hochenbegg (*Zeitschr. fur Klin. Med. Bd.* 62) says symptomatic varicocele can be distinguished from idiopathic varicocele in the following way : Let the patient lie down, at once the idiopathic varicocele disappears, only the relaxed condition of the scrotum remaining, but in the case of the symptomatic or secondary varicocele, this will become perhaps more tense on the patient assuming the horizontal position, or will in any case only slightly diminish in size. Symptomatic varicocele usually appears at an advanced age, and comes on more or less suddenly ; it is produced under various conditions ; the tumour may invade the renal vein and occlude the opening of the spermatic vein. This condition is, of course, only possible on the left side. The growth may infect the lymphatic glands, in which the spermatic and renal veins become imbedded and compressed. The spermatic vein may become occluded by the weight of the tumour ; it is in such cases that the varicocele becomes tenser when the patient lies down. The kidney may be dragged downwards by the weight of the tumour and the veins become kinked ; this occurs more frequently on the left side than on the right. The presence of a varicocele, due to either of the two last-mentioned causes, does not alter the prognosis, but if its presence is due to either of the two first-mentioned causes, then the case is inoperable. If posture and manipulation of the tumour is without effect on the variocele the prognosis is not good. Of sixteen cases of malignant tumour of the kidney observed by the writer, symptomatic varicocele was present in six of these patients. G.

An Improved Preparation for Intra-Muscular Injections of Mercury.—F. J. Lambkin (*Lancet*, July 6th, 1907) calls attention to a new preparation of the insoluble salts of mercury he has used with great success lately, the vehicle used for the suspension of the mercury being pure palmatin, which has the great advantage of being a soluble constituent of the organism, in place of the insoluble substances formerly used. The success which has followed on combining this preparation with camphorated creasote, as an analgesic, begins a new era in the treatment of syphilis by intra-muscular injections of insoluble salts of mercury, for, in the first instance, one great objection to the treatment, *i.e.*, the introduction of insoluble foreign bodies into the circulation—is done away with, and, in the second place, pain has been practically abolished, even in the case of calomel, so that this drug can now be used fearlessly in every case in which the surgeon thinks its use is indicated. G.

The Treatment of Lupus.—Dr. Drew (*Lancet*, July 13th, 1907) describes a method of treating lupus. The lupus patch to be treated is frozen with ethyl chloride till it is snow white ; over this frozen surface crude hydrochloric acid is rubbed in thoroughly, and with some degree of force. This thorough surface cauterisation should be carried out about once a week as long as it is necessary, that is, until only deeper nodules remain (lupus fibroma). The remaining nodules are cured by puncture cauterisation. The advantages of this method are : (1) It is simple, cheap, rapidly effective, and gives good cosmetic results ; (2) It can be carried out at home without hospital treatment, and this is specially important for patients with limited means ; (3) Complicated apparatus is not necessary, therefore the method can be applied by any practitioner.; (4) The method can be applied in all forms of lupus and in all situations, with the exception, perhaps, of the eye. Favourable results are obtained by repeated cauterisation, especially of lupus of the nasal cavity ; (5) As a preliminary for later Finsen treatment one gains time and gets favourable results. G.

Punctured Fractures of the Base of the Skull.—R. L. Knaggs, in a paper (*Lancet*, June 1st, 1907) on this subject, draws attention to the frequency with which such injuries as punctured fractures of the base of the skull are overlooked ; two or three days often pass during which the patient goes about as usual, then brain symptoms appear sometimes quite suddenly, and the patient may die in the course of a few hours. It is well to remember the paths by which a foreign body may reach the base of the skull. The most usual one is through the orbit ; the orbit is not necessarily entered from the front, but may be crossed from below upwards, or reached from inside the zygomatic arch, and the position of the skin wound may be such that it will arouse no suspicion that the brain has been injured. Another path is through the mouth, pharynx or nose ; this latter is very rare. Another not uncommon route passes through inside the zygomatic arch, the external wound is usually in the cheek and the lower jaw may be damaged. Lastly, the convex portion of the posterior segment of the skull may be wounded directly. It is also well to remember that often such wounds are regarded by patients as trivial, and they may only seek advice with the onset of brain symptoms. In cases where the foreign body inflicting the wound is long, slender, and brittle, a portion may readily be left behind, and retained in the skull. Lastly, it is well to remember that even if the immediate danger of death from cerebral hæmorrhage or injury is escaped there is a tendency to later septic complications, which may be deferred for several days. At the base of the skull the majority of the venous sinuses are situated ; it is unfortunate that the converging walls of the outer part of the orbits tend to direct a weapon towards this dangerous area. G.

Obstruction of the Central Retinal Vein.—Verhoeff, Boston (*Ophthalmic Review*, December, 1906) in dealing with the pathological findings of six cases of his own and twelve reported cases diagnosed ophthalmoscopically as thrombus of the central vein, brings evidence to show that the most frequent cause of the clinical picture is an endo-phlebitis proliferans. Out of the cases reviewed, in only two was the central vein thrombosed, and these were septic cases. A coagulum due to the fixing agent may resemble a thrombus, but in the majority of the cases the evidence was insufficient to show that it was due to thrombus, but rather indicated that it was due to an endo-phlebitis proliferans. The obstructing mass showed no blood remains, such as blood pigment, and the adventitia around the obstruction showed no signs of inflammation, but the mass consisted either entirely of connective tissue or partly of proliferated endothelial cells. The anatomical examination of all the cases save one showed the presence of glaucoma. In one of Verhoeff's cases acute glaucoma set in three weeks after the onset of the symptoms of obstruction of retinal vein. The eye had to be enucleated for pain and showed, on examination, an absence of a thrombus, and the presence of complete occlusion of the vein due to an endo-phlebitis proliferans. There was no cupping of the disc, but the glaucoma seemed to have been due to excess of albumen in the vitreous, derived from the retinal veins and capillaries. This excess of albumen was shown by the vitreous being found coagulated by the action of the formalin, when the eye was divided. Conclusion.—Complete obstruction of the central vein, with classical ophthalmoscopic picture of thrombosis of this vessel, may be produced by endo-phlebitis proliferans without thombosis. The proliferation may involve the sub-endothelial tissue alone, or the obstruction may be completed by a more active endothelial proliferation into the lumen. All of the cases anatomically examined in which obstruction of the central retinal vein has been attributed to non-septic thrombosis can be explained by, and in all probability were due to, endo-phlebitis proliferans alone. In certain cases obstruction of the central retinal vein may early give rise to acute glaucoma. M.

Medical News in Brief.

Liverpool School of Tropical Medicine.

Sir Alfred Jones presided at a dinner given on July 15th, at Liverpool, for the purpose of bidding farewell to Dr. J. L. Todd (late director of the Tropical Research Laboratories at Runcorn), who is returning to Canada, and to bid God-speed to Dr. Barrett and Dr. Yorke, members of the Black Water Fever Expedition, who are going out to Africa. The company included the Bishop of Liverpool, Lord Mountmorres, Sir Rubert Boyce, F.R.S., Professor Ross, C.B., Professor Carter, Dr. Caton, the American Consul (Mr. Griffiths), and the Mexican Consul-General in Liverpool. Sir Alfred Jones and Sir Rubert Boyce spoke to the toast of farewell to Dr. Todd, the latter remarking that the doctor was the finest example of an Imperial student. Coming from Canada, he had been willing to work in every part of our Empire, and, while giving his time and talents, he had also contributed something like £200 per annum to the Tropical School, and, more particularly, to found the institution at Runcorn, where the best scientific work had been done. He (Sir Rubert) hoped that that institution would be firmly united to the Liverpool School of Tropical Medicine. He would also like to see another expedition sent out in connection with sleeping sickness, for having, they believed, found the means of preventing that disease, it was their duty to push the treatment as much as possible. Dr. Todd said that the school had shown very little gratitude for the work of Dr. Dutton, who died whilst engaged in research work. They had tried to collect sufficient to establish a professorship in his honour, but of the £16,000 required only £4,000 had been received. The Bishop of Liverpool proposed success to the Black Water Fever Expedition, and paid a high tribute to the work of the School of Tropical Medicine, which, he said, had been wonderfully successful in enabling European civilisation and Christianity to lay hold of peoples who some time ago knew them not. It was highly satisfactory that London and Liverpool joined hands in sending out that expedition. Professor Ross supported the toast, which was acknowledged by Drs. Barrett and Yorke. On the motion of the American Consul, the toast of "The Study of Tropical Medicine" was honoured, and was responded to by Colonel Bruce, who said that the Mediterranean fever, which had been the dread of the Army at Malta, had practically been blotted out.

Joint Stock Companies and the Practice of Dentistry.

Judgment has been given during the past week in the Irish Courts in a case of very great interest and importance to the medical and dental profession. The case which was heard some weeks ago has been already mentioned in these columns. In brief, it consisted in an application by the Attorney-General at the relation of Mr. Kevin O'Duffy, Hon. Secretary of the Irish Dental Association, claiming an injunction to restrain Myddleton, Limited, a Belfast company, and its members from practising as surgeon dentists, and the directors from permitting the company to remain on the registry of Joint Stock Companies.

Mr. Justice Barton, in giving judgment, said in applying to the present case the authorisation which had been cited during the hearing, the particular form and character of this proceeding had to be borne in mind, as well as the peculiar nature of the rather scanty evidence which the plaintiff had laid before the Court. He could not say that the memorandum of association in this case was open to legal objection. The title of the company did not contain the word dentist or any of its synonyms, or any allusion to dentistry. The principal purpose of incorporation was to carry out dental operations by means of properly qualified persons—a purpose which is not *per se* illegal. If the company were to carry out dental operations by means of unqualified persons, serious questions might arise, including the question of *ultra vires*. But there was no evidence in this case upon that question of fact. The Court did not know who had carried out the dental operations of the company. Therefore the plaintiff claimed wider relief than the evidence justified. The plaintiff, had, however, established his right to the relief claimed in restraining the defendants from registering the company as dentists. In conclusion, the judge said: "I am disposed to think that defendant's counsel endeavoured to form upon Jaffe's case a larger claim of privilege for companies than the decision in that case will support. They claim for limited companies as a result of that case an unobstructed right to use the word, 'dentist,' or its synonyms in any and every shape and in any and every context. Jaffe's case decided that the word 'person,' in Section 3 of the Dentists Act, 1878, does not include individual persons, and that the Section hits individuals but does not hit limited companies. But a company, although it may be exempted from the penalties imposed by that Section, is not, in my opinion, thereby privileged to make false representations which are calculated to mislead the public as to the qualifications of the individuals whom it composes or employs. There will be an injunction to restrain the defendant company and the directors and members thereof from employing the defendant Alfred Myddleton under the title of surgeon dentist or dentist, to carry on business under the memorandum of association of the said company, and from holding forth or representing in the register of directors and managers, or the reports or returns pursuant to the Companies Act to the registrar of joint stock companies, or in their advertisements to the public, or otherwise, or elsewhere that the defendant Alfred Myddleton is a dentist, or that the defendant company comprises or employs persons of the name of Myddleton who are dentists. The plaintiff had practically succeeded, and if he had limited his claim he would be entitled to the whole costs of the action. The order as to costs will be that the plaintiff shall have the costs of the action save in so far as they may have been increased by the relief claimed in other parts of the statement of claim."

Society for the Relief of Widows and Orphans of Medical Men.

At the quarterly Court of Directors of this Society, held on July 10th, Dr. Blandford, President, in the chair, twenty-one directors were present. The deaths of Sir William Broadbent and Dr. Robert Barnes were reported; both had held the office of director. The Secretary was directed to send letters of condolence to Lady Broadbent and Mrs. Barnes. Two new members were elected. Since the last quarterly Court one of the widows, an annuitant of the charity, had died. Her husband paid a life subscription fee of £26 5s., and the widow had received in grants the sum of £490. Six letters had been received from widows of medical men, asking for relief, but in each instance this had to be refused as their husbands had not been members of the Society. The sum of £1,300 10s. was voted for the half yearly grants to the 49 widows and 20 orphans, at present on the books of the Society. Membership is open to any registered medical practitioner, who at the time of his election is residing within a twenty-mile radius of Charing Cross. Full particulars may be obtained from the Secretary at 11 Chandos Street, Cavendish Square, London.

Ulster Medical Society.

At the annual meeting of the Ulster Medical Society, the President, Dr. Gaussen (Dunmurry), in the chair, Dr. Howard Stevenson, the honorary secretary, read the annual report of council. Dr. Fielden, honorary treasurer, presented the statement of accounts, showing a balance in favour of the society of £30 10s. 8d., and Dr. Storey, honorary librarian, presented the library report. The following were elected office-bearers for the ensuing session, 1907-8: President, Dr. John McCaw, Senior Physician to the Belfast Hospital for Sick Children; Vice-Presidents, Dr. A. Fullerton and Dr. Wallace; Treasurer, Dr. Fielden; Librarian, Dr. Storey; Secretary, Dr. Howard Stevenson; Editing Secretary, Dr. Rankin; Council, Drs. R. J. Johnstone, T. Houston, S. A. Craig, A. G. Robb, W. St. C. Symmers, W. B. McQuitty.

North-East London Post-Graduate College.

A vacation course will be held at the Prince of Wales' General Hospital, Tottenham, during the coming September, commencing on the 9th of the month, the arrangements for which have been adapted to the requirements of those engaged in active practice. They include daily cliniques in the wards, demonstrations in the out-patient and special departments, classes on clinical methods. Other practical clinical demonstrations and clinical lectures with lantern demonstrations. The fee for the course, which will last a fortnight, is one guinea. Further particulars of the course may be obtained from the Dean of the Hospital.

Royal College of Surgeons in Ireland: Fellowship Examinations.

Notice is hereby given that on and after January 1st, 1910, all examinations for the Fellowship of this College will be conducted under the scheme of examination now known as Grade I. No candidate after the above date will in any circumstance be admitted to examination for the Fellowship of this College under the scheme now known as Grade 2, which will then cease to be used.

The United Services Medical Society.

At the first meeting of the Council of this newly-formed Society, it was decided that meetings be held at the Royal Army Medical College at 8.30 p.m. on the second Thursday in each month, commencing on October 10th, 1907; that the annual subscription be 5s., payable in advance; and that a notification of the formation of the society accompanied by an invitation to join be sent to all medical officers on the active lists and to those on the retired lists whose addresses can be discovered. Should any medical officer on the active or retired list of the Navy, the British and Indian Armies, or the Auxiliary and Colonial Forces not receive an invitation, the Council hope that, if desirous of joining the society, he will communicate with one of the honorary secretaries, Fleet-Surgeon W. W. Pryn, R.N., "Tredown," 25 Idmiston Road, West Norwood, S.E., or Lieut.-Colonel C. H. Melville, R.A.M.C., Royal United Service Institution, Whitehall, S.W.

PASS LISTS.

University of Glasgow.

The following candidates have passed the fourth (final) professional examination for M.B., Ch.B. The names are arranged alphabetically.

W. W. Adamson, G. V. Anderson, A. H. Arnott, David Arthur, B.Sc., Herbert Bertram., R. L. Binning, William Brown, M.A., B.Sc., James Cairncross, T. H. Campbell, R. P. Cartwright, T. G. Copestake, A. J. Couper, A. D. Cowan, J. R. Craig, C. A. Crichlow, Neilson Davie, H. W. Dempster, J. A. Doctor, Donald Duncan, W. H. Duncan, Allan Dunsmuir, L. J. Dunstone, A. W. Eadie, W. M. Elliott, A. Fairley, T. H. Forrest, Thomas Forsyth, Berkeley Gale, George Garry, James Gemmell, David Gibson, H. M. Granger, J. V. Grant, T. P. Grant, W. C. Gunn, Lawrence Hislop, Archibald Hogg, A. J. Hutton, C. L. Kerr, A. T. I. Macdonald, Neil MacInnes, M.A., Robert McInroy, J. B. Mackay, T. C. Mackenzie, A. D. M'Lachan, D. C. Maclachan, A. N. R. M'Neill, C. J. C. Macquarie Carswell Marshall, J. H. Martin, Horatio Matthews, W. S. Melville, J. C. Middleton, M.A., B.Sc., J. W. Miller, Thomas Miller, M.A., J. R. Mitchell, Hugh Morton, James Muir, R. C. Muir, Patrich O'Brien, D. M. Reid, Donald Renton, M. M. Rodger, T. D. C. Ross, Alexander Scott, J. M. Smith, John Steedman, C. K. Stevenson, M. J. Stewart, Lawrence Storey, J. A. Struthers, J. M. Taylor, R. S. Taylor, D. A. Thompson, M.A., H. J. Thomson, J. A. Thomson, Robert Todd, John Turnbull, Martin Turnbull, W. B. Watson, John Weir, F. R. Wilson, Samuel Wilson, M.A., W. M. T. Wilson, Thomas Winning, M.A., G. Yeghia Yardumian Matthew Young.

Women.—Jeannie Montgomery Andrews, Martha Maclean Buchan, Margaret Gardner Forrest, Ella Smith Hill, M.A., Annie M'Crorie, Janet Annie Macea, Jessie Deans Rankin, M.A., B.Sc.; Jane Isabel Robertson, M.A.

The following passed with distinction in the subjects indicated:—

In (*a*) Surgery and Clinical Surgery (*b*) Practice of Medicine and Clinical Medicine—David Arthur, B.Sc., Hugh Morton, Matthew John Stewart.

In (*a*) Surgery and Clinical Surgery (*b*) Midwifery—William Cooper Gunn.

In Surgery and Clinical Surgery.—Jeannie Montgomery Andrews, William Brown, M.A., B.Sc., Martha Maclean Buchan, Thomas Hay Campbell, James Robert Craig, Charles Adolphus Crichlow, Donald Duncan, William Marley Elliott, Archibald Fairley, Margaret Gardner Forrest, Samuel Nicol Galbraith, Berkeley Gale, James Wilfred Georgeson, Henry Maxwell Granger, Thomas Purdie Grant, James Dow Gray, Ella Smith Hill, M.A., Archibald Hogg, Andrew James Hutton, Thomas Miller, M.A., Daniel M'Kinlay Reid, George Waugh Scott, John Steedman, Campbell Kay Stevenson, Lawrence Storey, David Alexander Thomson, M.A., Hugh Johnstone Thomson, Samuel Wilson, M.A., Matthew Young.

In Practice of Medicine and Clinical Medicine—John M'Vittie, Horatio Matthews.

In Midwifery—Allison David M'Lachlan, Alexander Scott.

Royal College of Surgeons of Edinburgh.

The following gentlemen, having passed the requisite examinations were, at a meeting of the College held on the 16th inst., admitted Fellows:—Edward Archer-Brown, M.B., M.R.C.S. Eng., L.R.C.P. Lond., Johannesburg; William Bruce Bell, M.B., C.M., Manchester; Alexander Glover Coullie, M.B., Ch.B., Pencaitland; David Elliot Dickson, M.B., C.M., Lochgelly; William Arnott Dickson, M.B., Ch.B., Lochgelly; Henry Tristram Holland, M.B., Ch.B., Baluchistan; William Leonard Maccormac, M.B., Ch.B., London, S.W.; Archibald McKendrick, L.D.S., L.R.C.S.E., Kirkcaldy; Charles Edmund Russel Rendle, M.R.C.S. Eng., L.R.C.P. Lond., Plymouth; Herbert Wilkinson Riggs, M.D., C.M., Vancouver; Geoffrey Allen Upcott-Gill, M.R.C.S. Eng., L.R.C.P. Lond., London, N.W.; and William Young, M.B., C.M., Major, Indian Medical Service.

Society of Apothecaries of London.

The following candidates, having passed the necessary examinations, have been granted the L.S.A. Diploma of the Society, entitling them to practise Medicine, Surgery, and Midwifery:—E. R. Bastard, M. L. Ford, A. J. Hopper, R. J. W. McKane, G. B. Messenger, E. E. C. Vollet, and J. S. Ward.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.**

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

A LAYMAN.—We cannot publish letters from laymen when they are evidently not inspired by public spirit, but rather prompted by private feelings of malice or spite.

QUOD.—Medical men's ordinary earnings from practice and appointments will, of course, be chargeable on the ninepenny basis, but it is the individual's own responsibility to see that he gets the abatement. Unless the claim is made the surveyor, with the usual red-tape methods of administration, will not be bound to call the taxpayer's attention to his rights. A special form (which we are advised is not yet available) is being printed, and will be distributed at the surveyor's pleasure, but if it is not sent in by September no allowance will be made. Your best plan then will be to write to your surveyor and make his life a burden till you get a form out of him.

THE TREATMENT OF HAIRY MOLES.

QUERY writes:—"I should be glad if any of your readers could tell me briefly what is the best treatment for hairy moles in a girl aged 11, the moles being situated on the face, and the parents not sufficiently well off to send her to a specialist or even to town for hospital treatment. Have X-rays been of any value in this condition?"

MR. EDWARD B.—The marked communication reached us as we were "at press," too late for reference in present issue.

COUNTRY PRACTITIONER.—Possibly enemata, or suppositories of glycerine would be found beneficial.

R. P.—There are several agencies that deal in the placing of resident patients with medical men. Some of them are very shady affairs and some quite straightforward. The Association of Medical Men receiving Resident Patients is clearly the one that appeals most directly to medical men, as it is entirely worked by medical men, and aims merely at being self-supporting. The address of the hon. secretary is 56, Outer Temple, Strand, W.C.

PLAGUE IN INDIA.

DR. RUTHERFORD last week asked the Secretary of State for India what was the number of deaths from plague during June in the Punjaub and in the whole of India; and what was the total for the six months in the Punjaub and in India.

Mr. Morley's reply was that the figures for June were:—Punjaub, 58,821 deaths; whole of India, 69,064. For six months ended June:—Punjaub, 632,953; whole of India, 1,060,067.

ERRATA.—In the paper published in our last issue entitled "Some Further Reflections on Cancer and Its Treatment," by J. A. Shaw-Mackenzie, M.D.Lond., at page 62, column 2, par. 3, line 10, " . . . animal tissues and organs. I have . . ." should read " . . . animal tissues and organs, I have . . . ." Page 63, column 1, par. 5, line 4 from bottom, " . . . fœtal secret*ion* . . . " should read " . . . fœtal secretin . . ."

SUBSCRIBER (London, S.E.)—We are glad to be able to ease your mind by saying emphatically that the institution you are interested in was not referred to.

MEDICUS.—Thank you for your letter and cutting. The matter is an important one and we hope to deal with it next week.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 24TH.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Skin (Dr. Meachen), Eye (Mr. Brooks), Medical Out-patient (Dr. Whipham).

THURSDAY, JULY 25TH.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND (11 Chandos Street, Cavendish Square, W.).—9.30 a.m.: Council Meeting. 11 a.m.: Annual Meeting. Election of Officers and Council. 2 p.m.: Address:—The President (Dr. P. W. MacDonald). Paper:—Dr. C. C. Easterbrook: The Sanatorium Treatment of Active Insanity by Rest in Bed in the Open Air. 7.15 for 7.30 p.m.: Annual Dinner at the Whitehall Rooms, Hotel Metropole.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson). 3 p.m.: Medical In-patient (Dr. Chappel).

FRIDAY, JULY 26TH.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND (11 Chandos Street, Cavendish Square, W.).—11 a.m.: Discussion on Psychiatry as a Part of Public Medicine (introduced by Dr. T. S. Clouston). Clinical Demonstration and Paper:—Dr. A. Wilson: The Psychology of Crime. Paper:—Dr. H. Devine: A Case of Katatonia in a Congenital Deaf Mute (illustrated with lantern slides). 2 p.m.: Communication.—Dr. W. F. Robertson and Dr. G. D. McRae: Observations on the Treatment of General Paralysis and Tabes Dorsalis by Vaccines and Anti-sera. Paper:—Dr. L. C. Bruce: Clinical Observations on Certain Cases of Mental Depression.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—9.30 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. Leslie).

Vacancies.

York Dispensary.—Resident Medical Officer. Salary, £190 a year, with board, lodging, and attendance. Applications to W. Draper, Esq., De Grey House, York.

The Cambridgeshire, etc., Asylum.—Second Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors, 18 Emmanuel Street, Cambridge.

Bradford Children's Hospital.—House Surgeon. Salary, £100. Applications to C. V. Woodcock, Secretary, Bradford.

Carmarthenshire Infirmary.—Resident Medical Officer. Salary, £100 per annum, with furnished apartments, board, attendance, fire, gas, and washing. Applications to Howell Howell, Secretary.

Salford Union.—Male Resident Medical Officer. Salary, £130 per annum, with furnished apartments and attendance. Applications to F. Townson, Clerk to the Guardians, Union Offices, Eccles New Road, Salford.

The Guardians of the Leeds Union.—Assistant Medical Officer. Salary, £120 per annum, with board, washing, apartments, and attendance. Applications to Jas. H. Ford, Clerk to the Guardians, Poor Law Offices, South Parade, Leeds.

Tunbridge Wells General Hospital.—House Surgeon. Salary, £100 per annum, together with board, furnished apartments in the Hospital, gas, firing and attendance. Applications to the Secretary.

Hospital for Sick Children, Great Ormond Street, London, W.C.—House Physician, House Surgeon, Assistant Casualty Officer. Stewart Johnson, Secretary. (See advt.)

Royal Southern Hospital, Liverpool.—Resident Pathologist and Registrar. Salary, £100, with board and residence. Applications to the Superintendent.

Appointments.

DIMOCK, HORACE, M.B., B.C.Cantab., M.R.C.S., L.R.C.P.Lond., Assistant House Surgeon at Addenbrooke's Hospital, Cambridge.

DOWLING, E. A. G., L.R.C.P., M.R.C.S., L.D.S., Lecturer in Dental Anatomy, Physiology and Dental Histology at University College, Bristol.

ELGOOD, OLIVE, M.S.Lond., Honorary Anæsthetist to the Birmingham and Midland Dental Hospital.

EVANS, WILLIAM OWEN, L.R.C.P., L.R.C.S., L.M.Edin., L.F.P.S. Glasg., District Medical Officer and Medical Officer to the Workhouse by the Pontardawe (Glamorganshire) Board of Guardians.

EYRE, J. W. H., M.D., M.S.Durh., Bacteriologist to Guy's Hospital.

FRIEND, JULIUS, L.S.A., Medical Officer to the No. 2 District by the Leeds Board of Guardians.

HITCHCOCK, NORMAN, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Resident Medical Officer to the Brixton Dispensary.

JONES, JOHN ARNOLD, M.B., Ch.B.Vict., F.R.C.S.Edin., Honorary Assistant Aural Surgeon to the Manchester Eye and Ear Hospital.

LOCHRANE, FRANK J., M.D., B.S.Glasg., Honorary Gynæcologist to the Derbyshire Royal Infirmary.

McEWAN, PETER, M.B., Ch.B., F.R.C.S.Edin., Resident Surgical Officer at the Bradford Royal Infirmary.

PEDLEY, F. NEWLAND, F.R.C.S.Eng., L.D.S., Consulting Dental Surgeon to Guy's Hospital.

PERRY, FREDERICK W., L.D.S., Demonstrator in Dental Anatomy, Physiology and Dental Histology at University College, Bristol.

PILLIN, H. L., L.D.S., R.C.S.Eng., Dental Surgeon to Guy's Hospital.

PRICE, HENRY J., F.R.C.S.Eng., Medical Referee under the Workmen's Compensation Act, 1906, for County Court Circuit No. 38, and to be attached more particularly to Braintree, Chelmsford, Colchester, Dunmow, Halstead, Harwich, and Maldon County Courts.

Births.

HUDSON.—On July 19th, at Sarratt Hall, Sarratt, Herts, to Dr. and Mrs. Hudson, a daughter.

NEWBOLT.—On July 16th, at 42, Catharine Street, Liverpool, the wife of George Palmerston Newbolt, F.R.C.S., of a daughter.

PERIGAL.—On July 15th, at Blenholme, new Barnet, Herts, the wife of Arthur F. Perigal, M.D., of a daughter.

Marriages.

AYERS—SHACKLETON.—On July 18th, at St. Bartholomew's, Sydenham, the Rev. Frank Ayers, M.A., Vicar-Designate of St. Michael's and All Angels', Sydenham, to Ethel Rose, third daughter of Henry Shackleton, M.D., West Hill, Sydenham.

COCKE—ATKINSON.—On July 17th, at St. Paul's Church, Crewe, Thomas Dudley, eldest son of the late Thomas Henry Cocke and Mrs. Cocke, of 84, Harley Street, to Mirion, third daughter of Dr. and Mrs. Atkinson, J.P., of Mirion House, Crewe.

Death.

JEAFFRESON.—On July 21st, at the Hostel of St. Barnabas, 31, Harman Street, Hoxton, London, Jemima, second daughter of the late John Furrance Jeaffreson, F.R.C.S., of Canonbury Lane, London.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, JULY 31, 1907. No. 5

NOTES AND COMMENTS.

The Work Cure.

THAT fashion in treatment varies nearly as much as fashion in ladies' hats is an undeniable fact, but it may be hoped that whereas the latter leads nowhere, the former is showing a rational and upward tendency. The Weir-Mitchell cure is certainly not as popular, at all events with patients, as it was a few years ago, and, in searching for a successor, it may be that an excursion in precisely the opposite direction will be healthful and healing. Already in sanatoriums for consumptives, notably at Frimley, the value of work is beginning to be demonstrated, and there is no doubt that in asylums a great many improvable patients are a great deal better occupied in practising mechanical handicrafts than in lounging about watching cricket-matches. Some very interesting experiments are reported from Vienna of the value of work at the State Institution for Mental Diseases at Mauer Oehling. Dr. Starlinger, the superintendent, has more than half his patients at work of some kind—agricultural, dairy, farm, or mechanical. Moreover, for those of a literary turn he gives facilities for the production of a newspaper, and a periodical largely written and composed by the patients is published in the asylum. We have not had the advantage of seeing a copy, but we can imagine it would be sufficiently entertaining to rank, let us say, with *Punch*. The important point is that all this work is of great benefit to the inmates, and the work-cure may eventually invade our shores as successfully as the rest-cure did ten years ago.

Sir Thomas Fraser Redivivus.

SIR THOMAS FRASER, like Lord Brougham and Mark Twain, has had the curious experience of seeing himself killed before his own eyes, though he has not, we believe, shared with Sir Harry Parkes and a few other eminent people the exquisite enjoyment of assisting at his newspaper post-mortem. The mistake arose in the Lord Chamberlain's office, it seems, in the same way that most mistakes and injustices arise in government departments, namely, by junior clerks doing the work for which their seniors are supposed to be responsible. We should have thought that even junior clerks would have had at their command sources of information with regard to eminent men which would have enabled them to verify such important facts as to whether they were alive or dead; indeed, it is inconceivable that two minutes' conversation on the telephone with the Scottish Office would not have brought authentic news. For our own part, we were led by the Lord Chamberlain's information to announce that Sir Thomas Fraser had been succeeded by Sir Thomas McCall Anderson in the office of physician to the King in Scotland, whereas, of course, he had only been joined in that office by Sir Thomas, who succeeded the late Sir William Gairdner. As there had been other changes in the King's medical attendants, we hoped that the announcement was preliminary to even higher honours. At any rate, we trust that he will be spared for many years to enjoy the marks of confidence he has deservedly earned from the Sovereign.

County Courts and Debt Collecting.

A LETTER opening up a question of much importance to medical men appears in our correspondence columns this week. It seems that Judge Mulligan, K.C., who has recently been raised to the bench, has started by reversing the practice of his predecessor, and we believe of most if not all County Court judges of the present day, with regard to the collection of small debts. Now, there are few medical men with a large *clientèle*, especially in scattered and unsettled districts, who are not compelled to make use of the County Court more or less frequently to get in their small debts. The total these small amounts reach in the course of a few years is sometimes astonishing, and in self-defence most medical men have to take steps with regard to them, if only to get rid finally of undesirable patients who call them up at all sorts of hours and never pay their bills. Now the collection of trivial debts by the full legal process is an expensive and inefficient method, and though no one grudges paying a solicitor for advice and work, it is ridiculous that his costs for proceeding in the case of a small debt should amount to more than the debt itself, and that the money should frequently never be recovered after all. It is like using a steam-hammer to crush a fly. Of late years, a class of debt-collectors have sprung up who work entirely on commission, and who, by means of calling on debtors, are frequently able to make some arrangement with them whereby instalments may be paid with reasonable regard to the amount and frequency of their wages. The remuneration of the debt-collector is very small, but he is able, by making a speciality of his business to get a living out of it. The debt-collector is an honourable man, as a rule, and is a good friend to doctor and poor alike.

Judge Mulligan and Paid Agents.

When a debtor has been found impervious to argument and it is decided to proceed by means of the County Court, it is a great convenience for a medical man to leave everything in the collector's hands and not to have personally to appear in undisputed cases. Indeed, a common practice is for a collector to arrange with a debtor as to when and how the debt shall be paid, and, having got his formal acknowledgement, to appear in Court and obtain an order to that effect. Now Judge Mulligan has decided to sweep away all this practice, and he is refusing to hear collectors who appear before him. He speaks of the previous custom as a "nefarious practice," which he will not permit. Now, if his Honour had given some reason for his action it might have been possible to understand why he should regard it, the custom of his predecessor and his senior colleagues, as nefarious, but all we can gather from a lengthy report of some proceedings in his Court is that he regards it as very wrong for a paid agent, not a solicitor, to appear for anyone else. As reasonable beings we cannot think why it should be "nefarious" to pay an agent not a solicitor to appear in Court, and not equally nefarious to pay a solicitor. As a matter of fact it seems to be simply and solely a question of solicitor's privilege. A lawyer does not like irregular practitioners to appear in Court any more than a doctor likes an irregular practitioner to practise medicine, and we should certainly wish to support the lawyer in such a claim if it were not for certain points of public policy.

Lawyers and Collectors.

As law-courts and lawyers are made for the public, it stands to reason that if they are not able to do the public work, the public must make other arrangements. This is what has happened with regard to petty debt-collecting. It is in spite of the lawyers, who did not find it worth their while to organise the work on a large scale, that creditors have been able to get in petty debts, and no doubt it is hardly solicitor's work to spend days and weeks getting in half-crowns and five-shilling bills, many cases involving several visits and letters. In fact, if Judge Mulligan has his way, small debtors will enjoy their previous immunity again. In these circumstances we cannot see why it should be proposed to forbid collectors of good character to appear in court in purely formal and uncontested cases to prove debts. Only a fortnight ago, in the Clerkenwell County Court, a company sent one of its employees to conduct a disputed case on its behalf, and Judge Edge held that he ought to allow him to give his evidence of the debt—which is all the debt collector wants—though he would not allow him to examine and cross-examine. If Judge Mulligan, who has yet to earn his experience on the bench, proposes to be a law unto himself, there will have to be found means for testing the value of his decision.

Notification of Consumption.

Dr. J. F. J. Sykes, medical officer of health, in a recent report issued :—"The experience of St. Pancras during the time that voluntary notification of consumption has been in force appears to coincide with that of nearly all other local authorities which have adopted the same course. This experience is that voluntary notification is ideal in theory, but of little value in practice, because the number of cases notified is very small, and the notifications often take place when the patients are moribund."

LEADING ARTICLES.

THE CAMPAIGN AGAINST QUACK MEDICINE.

The evil wrought by the yearly increasing sale of quack medicines has assumed the dimensions of a national scandal. Vast sums of money are expended annually in advertising nostrums claiming to cure the incurable and to work miracles that are clearly outside the range of human achievement. In other words the claims of the vendors are false, therefore their business is a fraud, and the newspapers that accept their advertisements are participating in the proceeds of a fraudulent transaction. That is the plain English of the matter. Worst of all, this traffic is sanctioned by the State, which draws a paltry yearly revenue from patent medicine stamps. This, be it remembered, is the great, omniscient State that jealously insists upon the thrice-tested knowledge of its qualified medical practitioners, but none the less allows its subjects to be fleeced on all hands by quacks and nostrum-vendors. This, too, is the paternal State that wrings its hands in despair at the physical degeneracy of our race, at the high infantile mortality, and the unnecessarily high death rates of many of our great towns. It would be interesting to speculate on how much of that physical degeneracy, and how many of those wasted lives are due to quacks and quackery. Some day the State will doubtless wake up and expel the enemy that is within our gates. Then we shall probably have the Royal Commission of Inquiry into quacks and quackery that has been for some time past demanded in season and out of season by The Medical Press and Circular. Happily signs are not wanting that the conscience of the nation is being slowly awakened to this great evil. The matter is now and then dealt with forcibly by Coroners who are brought face to face with many of the disasters directly caused by this nefarious traffic. The judges of the land occasionally utter a scathing denunciation when a case of quackery comes within their jurisdiction. The matter, again, is discussed freely in medical journals and in medical societies in all parts of the world. But perhaps the most significant movement is the revolt of the dispensing chemists against proprietary and secret remedies. Last week the Federation of Local Pharmaceutical Associations met in Manchester and listened to a capital paper by Mr. J. Cofman, of London. For downright plain speaking this gentleman's essay would be hard to beat. He divides "proprietary" into three classes, of which one includes what may be called the more respectable articles, the composition of which is no secret, but which represent genuine drugs prepared by special methods, and not sold under false colours. A second group deals with "frauds that have somehow escaped the courts of law, all of secret composition and claiming to cure every imaginable disease." "To stock and to sell these quack medicines," says Mr. Cofman, "is a disgrace for a respectable person." The third class is that of old or well-known drugs or compounds claiming special virtues under the ægis of some particular name. These "proprietaries" are spoken of as "in the highest degree injurious to the present interest, and to the future interest of pharmacy." The author of this vigorous onslaught invokes the co-operation of the Pharmaceutical Society and of the General Medical Council in the attempt to secure legislation for the proper control of the traffic in secret remedies. There can be little doubt that if the chemists decide to fight this great evil the proprietors of the baser sort of proprietory remedies will find their trade seriously threatened, if not, in many instances, altogether destroyed. As far as the policy of this journal is concerned we can only say that we shall welcome the powerful aid of the pharmaceutical societies in fighting what we regard as a national scandal. There is admittedly a material interest concerned in the case of the chemists, but there is no reason to assume that their motives are on that account less straightforward and honourable than those, let us say, of the medical profession. If the pharmaceutical chemists resolve to rid their profession of this unclean thing, they would earn the esteem of all right thinking men. Should they form a strong policy and a strong organisation they will find abundant opportunity of distinguishing themselves in a resolute campaign that must sooner or later be undertaken.

CURRENT TOPICS.

The British Medical Association and the General Medical Council.

For many years the British Medical Association has been debating the question of taking on the functions of a defence society on behalf of its members, but various obstacles, legal and otherwise, have stood in the way. Although there is some doubt as to whether the Association has so far officially authorised actions appertaining to a defence society, one of its many committees has assumed authority in the matter, and proposes to appear as prosecutor in penal cases before the General Medical Council. The Council of the Association has declined to express any opinion as to the powers of the committee so acting, and the position at present is one of much confusion. The only tangible result is that Professor Saundby and some other members of the General Medical Council who were also members of the Association, have cut their connection with the latter. Whether it be wise or not for the Association to take on such duties in defence of its members is a matter for themselves, but obviously if it is to be done it should be done regularly and formally, and members should know where they stand. It is not for an irresponsible sub-committee to decide a great question of policy for an association of several thousand members. Moreover, in the present state of the by-laws of the Association, it is very doubtful if money can be legally spent in the prosecution of cases before the General Medical Council. It is to be hoped that the Representative Meeting this week will come to some authoritative decision.

Fourth of July Fatalities.

Though the full records of the Fourth of July fatalities in the States are not yet available, it is to be feared that the tale of victims will be nearly as great as in previous years. Year after year the medical and some lay journals have preached against the insane antics to which the patriotic youth of the country gives itself up on the national anniversary, but, except in one particular, their preaching has had little effect. Toy-pistols, fire-crackers, noise-producers of all sorts, are as much in vogue as ever. And year after year the national anniversary claims its hecatomb of human victims. One of the Chicago papers, appearing on the morning of the 6th, was able to report 59 fatal accidents and 3,807 injuries which had occurred during the previous two days. In Pittsburg alone, 15 violent deaths occurred during the celebration of the national festival. The one particular in which for the past few years there has been progressive improvement is the incidence of tetanus. Only five or six years ago tetanus was a common sequel of comparatively trivial wounds received from toy explosives. The medical journals, by teaching that all wounds of the sort should be treated by the open method, have succeeded in reducing the mortality from this disease to a very low figure.

The Effects of "Belated Ovaries."

The complete reversal in the treatment of certain uterine diseases, which has led operators to discard principles which lead to the removal of the ovaries and the retention of the uterus, in favour of principles which lead to the removal of the uterus and the retention of the ovaries has been amply justified by its results. In consequence, there are now but few gynæcologists, and their number is rapidly diminishing, who do not recognise the extreme importance of retaining in every possible case even of a portion of an ovary. We publish in to-day's issue a clinical lecture from the pen of Mr. J. Bland-Sutton on this important subject. His views are in entire accordance with the most recent gynæcological opinions, and his practical experience is very welcome as a means of convincing the few who still remain satisfied with the older teaching.

An Open-Air Schoolroom.

A novel and interesting experiment is being conducted by the London County Council in the shape of an open-air school, opened last week at Plumstead. The scheme is carried out in connection with the Woolwich group of special schools. The children have been selected from certain schools in Woolwich, Greenwich, and Deptford, and admission is granted only to those who are suffering from anæmia or from tuberculous affections. There were no less than 300 applications from parents for the 120 vacancies. In fine weather the children recline in deck chairs in the open, while a well-built shelter is provided for use in rainy weather. This new departure is in touch with the teachings of modern medicine, and its wider application to healthy children, were that possible, would be a desirable thing. Clearly it is far better to cure children in an open-air school rather than to have to attempt the same thing in a sanatorium under the less promising conditions of later life.

The Hygiene of the Swimming Bath.

Now that public swimming-baths are being adopted throughout the country, it is well to raise a note of warning as to their hygienic aspects. There is no need to insist that water should be renewed at frequent intervals, and that the bath should be emptied periodically and cleansed throughout, for we understand that such measures are already carried out. Clearly, however, the frequency of renewal of the water should be regulated by the number of bathers. Some public baths are immensely popular on cheap nights in the hot weather, and are patronised by hundreds of persons. Under such circumstances it would be obviously desirable to provide a rapid and continuous stream of water in and out of the bath. Another point is that bathers should be obliged to wash their feet, and obviously uncleanly persons should be thoroughly douched before going into the bath. Spitting should be punishable by expulsion, and a fine. In some parts of the Continent, such as Frankfort, regulations of the kind are enforced without any friction. The careful consideration of municipal authorities may be devoted with advantage to the hygiene of the bath. Nor is it less necessary in many instances on the part of those who are in charge of the cleansing operations of our poor-law institutions, barracks, prisons, and reformatories.

Fees for Certificates under Workmen's Compensation and Education Acts.

Under the new Workmen's Compensation Act, there must inevitably arise a great many cases in which medical certificates are necessary either in the prosecution or the defence of claims. Medical men, therefore, will do well to insist that an adequate fee is paid for their signature to every document of the kind, and it seems not unlikely that the scale of future remuneration will be to a great extent determined by their first stand in the matter. The Council of the Irish Medical Association has issued broadcast a resolution advising all medical men to refuse any certificate in connection with the Workmen's Compensation Acts until payment has been guaranteed. The same body also advises refusal of certificates under the Education Act, until reasonable remuneration be granted. As regards the latter Act, it is certain that local authorities get a good deal of gratuitous service out of the medical profession on various pretexts. They demand, for instance, certificates for hospital patients suffering from ringworm, whooping-cough, and other infectious diseases. Quite recently a healthy child was brought to an out-patient department with a request for a certificate that he was in a state of good health. Unless medical men are warned in time they will quite possibly drift into a similar position as gratuitous (although, be it noted, indispensable) advisers under the Compensation Act.

Medical Referees and Workman's Compensation.

It will be of much interest to medical men to see how the new medical arrangements under the Workman's Compensation Act, 1906, work in practice, and whether the medical referee is going to be the arbiter as to a workman's destiny that our reading of the Act and rules make him. No doubt judges will not like to give up any of the authority they already possess, and some of them certainly will not do so without a struggle. A few days ago a case under the old Act came before Judge Shand sitting in the St. Helens County Court, in which the medical referee's report was not acted upon through the most extraordinary legal quibbles it is possible to conceive. The case was one of a collier who met with an accident to his knee in the course of employment last December, and who was receiving ten shillings a week as compensation from his employers, and six shillings and sevenpence a week from the Miners' Permanent Relief Society. In March, the man went to several doctors, who told him that his leg was well and that he was fit to return to work, but he was not satisfied, and was finally sent to the medical referee for the district, who certified him fit to return to work. However, later there was some further trouble, necessitating an operation on the leg, and the man sued the company for compensation. It was argued at this case that the medical referee's certificate was of no avail because he had not disclosed to the workman a statement at the time of examination that he was acting as referee, and also because the plaintiff went to him on the advice of a miner's agent. After much argument the judge decided that the referee's certificate was not conclusive evidence of the man's condition at the time of the accident, on the latter ground, and entered judgment for the workman. To the lay mind it seems the height of fatuity that a medical man's certificate is not evidence of a patient's health because one man and not another advised the patient to consult him, and still more that such a certificate should be capable of being over-ridden by a Court.

Leadless Glaze.

The desirability of the introduction of leadless glaze in the interests of the workpeople engaged in the pottery manufacture is obvious. From the humane point of view it is imperative, and hardly less so from the point of view of the social and political economist. As an industrial measure to prevent lead poisoning by eliminating the lead is simply an ideal step, embodying, as it does, the golden maxim that prevention is better than cure. On the other hand, it is only fair to hear what the manufacturers have to say upon the subject.

Recently one of them, writing to a London newspaper, stated that the leadless glaze involved a loss of 25 per cent. of the total output as against 5 per cent loss when lead was used. In reply, it may be urged that whereas the State has nothing to do with the cost to manufacturers and consumers, its plain duty is to protect the lives of the workpeople. The writer quoted went on to say that lead might be used safely if only employers, foremen, and workmen would work together and carry out rules. Experience shows that that kind of combination invariably fails in practice. The writer winds up by remarking that "there is a greater remedy." After stating that most male "dippers" have a female attendant working with them, and that marriage follows in many cases, he remarks: "The offspring are pre-eminently unfitted to follow their parents' occupation, and should not be permitted to do so." The candid employer has surely given his case away in the last sentence. To what other cause than lead could the degenerate offspring be ascribed?

Motoring and the Opsonic Index.

The open-air treatment of consumption stands out as one of the great therapeutic facts of the last century; but it may be doubted whether we have yet learned how to avail ourselves of its benefit to the fullest extent. At present it might be imagined that motoring would act as a sort of extension of that method available, at any rate, in the less advanced stages of pulmonary phthisis. Possibly the advantages thereby gained would be more than counterbalanced by the dust that is inseparable from that mode of transit. Medical science has now turned its searchlight upon the question of the effect of motoring upon tuberculosis, and has at once secured a striking and important observation. Specimens of blood were taken from Mr. S. F. Edge, both before and after his recent famous drive of twenty-four hours on a Napier motor. The first specimen was found to have a tuberculo-opsonic index of 0.85, while the second, taken directly after the race, gave 1.17. The fact that the active resistance of the body towards the tubercle bacillus was raised after so great a feat of endurance is not a little striking. The motorists may be pardoned if they plume themselves somewhat upon this scientific aspect of their fascinating pursuit. The remedy of a motor ride is more attractive than that of cod liver oil, even when presented in the form of a palatable emulsion.

PERSONAL.

Queen Alexandra, on the 24th instant, opened the new buildings of the Hostel of St. Luke, which have been built in Fitzroy Square, London, at a cost of £24,000 (including the site).

On the 23rd inst. H.R.H. the Prince of Wales accompanied by the Princess of Wales, opened the new out-patients' department at St. Bartholomew's Hospital, of which his Royal Highness is the president.

We are informed that Sir James Reid, Bart., M.D., G.C.V.O., K.C.B., has been appointed a director of the Clerical, Medical and General Life Assurance Society in the place of Sir John Williams, Bart., M.D., resigned.

Dr. Graham Steell, M.D. Edin., Fellow of the Royal College of Physicians, London, has been appointed Professor of Medicine by the Council of the University of Manchester.

The Nettleship Medal, founded in 1902, to commemorate the work of Edward Nettleship, and to encourage research in ophthalmology, was presented at the Annual General Meeting of the Ophthalmological Society to Mr. J. Herbert Parsons, for his monograph on the "Pathology of the Eye."

Professor Friedrich Muller has been awarded the Order of the Bavarian Crown in recognition of his professional eminence.

Dr. Thomas H. Bryce, has been awarded the Keith Prize of the Royal Society of Edinburgh for two papers on the Histology of the Blood of the Larvæ Lepidosiren Paradoxa.

M. Gilbert Ballet has been recommended for the Professorship of the History of Medicine and Surgery in the Faculty of Medicine of the University of Paris.

Deputy-Inspector-General Andrew Maclean, who is ninety-five years old is father of Kaid Sir Harry Maclean who is now in the hands of Raisuli, the brigand.

Mr. L. A. Dunn, M.S., F.R.C.S., Surgeon to Guy's Hospital, has been elected a member of the Court of Examiners of the Royal College of Surgeons of England.

Mr. A. Pearce Gould, M.S., F.R.C.S., Surgeon to the Middlesex Hospital, and Mr. W. B. Paterson, F.R.C.S., Dental Surgeon to St. Bartholomew's Hospital, have been re-elected to the Board of Examiners in Dental Surgery in the same institution.

The estate of the late Sir W. H. Broadbent, Bart., Physician-in-Ordinary to the King, who died on July 10th last, aged seventy years, has been valued at £86,209.

Dr. D. S. Lazarus Barlow has been appointed Croonian Lecturer for 1909.

Major C. E. P. Fowler, Assistant Professor of Hygiene at the Royal Army Medical College, has been appointed for special duty at Gibraltar.

Dr. Julius Dreschfield, M.D., of 3 St. Peter's Square, Manchester, whose death took place on June 13th, bequeathed everything he might die possessed of in trust for his children. The value of the property is sworn at £71,016 15s. 10d. gross, and £68,914 12s. 11d. net.

Dr. P. H. Pye-Smith will deliver the FitzPatrick lecture of the Royal College of Physicians of London this year.

Dr. Frederick Taylor has been appointed Harveian Orator by the same college.

The following gentlemen have been appointed to the other official lectureships as follows:—

To deliver the Milroy Lectures—Dr. J. W. H. Eyre.
To deliver the Croonian Lectures—Dr. A. E. Garrod.
To deliver the Goulstonian Lectures—Dr. H. S. French.
To deliver the Lumleian Lectures—Sir James Sawyer.
To deliver the Horace Dobell Lectures—Dr. L. S. Dudgeon.
To deliver the Oliver-Sharpey Lecture—Professor Schafer, F.R.S.

A CLINICAL LECTURE

ON

THE VALUE AND FATE OF BELATED OVARIES. (a)

By J. BLAND-SUTTON, F.R.C.S.,

Surgeon to the Middlesex Hospital, and Senior Surgeon to the Chelsea Hospital for Women.

The ovary is essentially an egg-producing organ, and from this aspect alone it may be described as a temporary and ductless gland, its period of activity being coincident with menstrual life, with an average period of thirty years. The structural changes in the ovary according to its age support the view that it should be classed with temporary secreting glands, for, after the age of forty it diminishes in size and after the forty-fifth year the ova and follicles begin to disappear; at fifty, when the menopause is usually established, the ovary may weigh about one-sixth of its weight at puberty, and consist merely of fibrous tissue traversed by a few blood vessels with thickened (sclerosed) walls. Careful observations have shown that complete removal of both ovaries is followed by sterility, arrest of menstruation (amenorrhœa), and in young women, by an alteration in the general metabolism of the body which is manifested mainly by the curious vaso-motor phenomenon known to women as "flushings." Observations on the effects of removing the thyroid have shown that this gland though ductless, supplies a secretion which finds its way into the circulating blood and exercises a great influence on general metabolism, especially in young and growing individuals; this has led many to believe in the production of an internal secretion by the ovary but no one has succeeded in isolating such a secretion, and its existence is hypothetical. One observer (Heape) has suggested the name "gonadin" for this secretion, but it is rather like fixing the name for a baby before it is born. There is, however, ample evidence to support the view that the ovary performs other functions in addition to ovulation, and that these, like some possessed by the thyroid and adrenal, are exercised to their fullest extent in early life, especially during the growth and development of the sexual organs. In regard to this matter it will not be out of place to mention the interesting observations published by Bullock, Sequeira, Adams, and others, concerning children who have exhibited precocious development of the sexual organs in association with the growth of tumours in the adrenals (suprarenal capsules). In some of these boys and girls, the secondary sexual characters, such as the growth of coarse hair on lips and chin, in the axilla, and about the pubes, have occurred at the age of ten and twelve years. In some of them the changes have taken place so quickly that in the course of a few months a boy or a girl has become transformed into a sturdy little man or woman, as the case may be.

It has long been known that in adults with tumours in the adrenals, pigmentation of the skin, different from that seen in Addison's disease, has been accompanied by an abnormal growth of hair on the skin generally; in at least one case the abnormal hairiness disappeared after the removal of the adrenal tumour. This association of precocious development of the sexual organs with some disorders of the adrenal is of interest in connection with the investigations which Heape made on the cause of rut in mammals, including monkeys, and which led him to express the opinion that the ovary is not the seat of the governing power of the breeding function. This view has not met with any support, and lately the observations of certain German workers, notably Fränkel, tend to invest the ovary with more extensive functions than physiologists have hitherto assigned to it, for the peculiar yellow body (corpus luteum) left in the ovary after the rupture of a ripe follicle, and which becomes such a conspicuous object on the cut surface of the ripe ovary when pregnancy occurs, is now considered to play an important part by means of an internal secretion it is supposed to furnish which assists the embedding of the oösperm (fertilised ovum) in the tubal or uterine mucous membrane. This secretion, Fränkel believes, is elaborated by the lutein cells which are derived from the follicular epithelium.

The result of modern research tends to exalt the importance of the ovary and indicates that its ovigenous function is by no means the only duty it performs. Precisely what these accessory functions are, and what the essence is in virtue of which they are exercised, nothing is known, but I am able to assert that a very small portion of an ovary is sufficient for their maintenance. The most obvious function associated with the ovaries is menstruation, and although the cause of this unpleasant phenomenon is obscure we know that the complete removal of both ovaries completely arrests it, and the congenital absence of both ovaries is always accompanied by amenorrhœa. An ovary in a well-developed healthy woman may weigh upwards of 100 grains; nevertheless, the presence of 15 grains of ovarian tissue containing follicles is sufficient to maintain menstruation and prevent the occurrence of flushings so characteristic of the natural, as well as the artificial menopause.

I will give briefly the details of two observations which illustrate this matter:—Some years ago, a single woman, æt. about 30, suffered severely from painful menstruation, and at her earnest entreaty her medical attendant performed what he believed to be a complete bilateral oöphorectomy. His chagrin was great, but the patient's disappointment was greater when she found during convalescence that her menstruation continued as regular and the pain as bad as before the operation. Many months later the patient sought my opinion, and I explained to her the difficulty of complete ablation of the ovaries and that there could be little doubt that a portion of at least one ovary had been left behind. For a long time I refused to interfere with the case, but at length, at the request of some of her friends, I re-opened the abdomen two years after the primary operation and found a portion of the ovary and the corresponding stump of the Fallopian tube with the ligature attached to the uterine cornu. That this piece of ovary was capable of fulfilling its function was proved by finding in it a recent corpus luteum a ripe follicle, and, on microscopic examination, ova in its tissues. The remnants of the ovary and tubes were carefully ex-sected from the uterus, menstruation ceased permanently, and in the course of convalescence flushings began to annoy the patient.

(a) A Clinical Lecture delivered at the Middlesex Hospital.

This is by no means an isolated case. On another occasion in which bilateral oöphorectomy had been performed by a gynæcologist for the relief of dysmenorrhœa, the operation produced no abatement of menstruation and apparently aggravated the pain. A year later I operated upon the patient and found active pieces of ovarian tissue on each stump, and to ensure complete removal of the ovarian tissue I removed the uterus.

For many years I have insisted that the complete ablation of ovarian tissue, except when the pedicles of the ovaries are elongated by the dragging of a tumour, is by no means an easy matter. On the other hand, when the uterus is occupied by a fibroid, the ovarian ligament is sometimes so short that the one or other ovary appears to be almost sessile on the uterus; in such conditions the complete removal of the ovary is an impossibility. I am able to demonstrate this by an actual specimen:—

A single woman, when æt. 28, had both ovaries removed at the Samaritan Hospital, London, for the relief of profuse menstruation due to a uterine fibroid. The operation did not arrest menstruation, but made it irregular and it remained profuse. Seven years later it completely ceased and remained in abeyance two years; then the flow reappeared and the patient noticed a swelling in the hypogastrium which increased in size, was painful, and interfered with micturition. In April, 1906, I performed hysterectomy, and found the uterus occupied by an interstitial fibroid which had undergone red degeneration (aseptic necrobiosis). On the right corner of the uterus there was a piece of ovary the size of a large ripe white currant. I have always maintained that it was an excellent effort of reasoning which led Lawson Tait in 1872 to the deduction that as uterine fibroids usually cease to grow after the natural cessation of menstruation, it would be useful to induce an artificial menopause in women with troublesome fibroids by removing their ovaries. He not only conceived the idea, but possessed the ability necessary to carry out the operation and convince the whole surgical world of the soundness and utility of the proceeding. In the quarter of a century succeeding Tait's brilliant observation, the surgery of the female pelvic organs had been brought to a high state of perfection, and hysterectomy can now be performed with less risk than bilateral oöphorectomy. This induced me to reverse Tait's operation by removing the uterus and leaving the patient at least one ovary. The reasons were practical enough, because as I have already mentioned, it is difficult to remove completely all the ovarian tissue and leave the uterus; the relief is neither prompt nor certain; convalescence is slow and often tedious, and with all these inconveniences and uncertainty there was a great disadvantage to the patient if the ovarian tissue was completely excised, for she would have the annoying signs of an artificial menopause.

These opinions were advocated at a meeting of the London Obstetrical Society in 1897, and led to much opposition, but they quickly gained support, and the speaker in the discussion who treated the idea of the conservation of the ovaries with derision, within a year became one of its most ardent advocates. To-day I am justified in stating that every surgeon who performs hysterectomy for the treatment of uterine fibroids always seriously considers the conservation of at least one ovary in women æt. under 40 a matter of prime importance, and some believe in the value of preserving an ovary even at any age.

It is now admitted by surgeons who have had much experience of hysterectomy for fibroids that the immediate results of preserving at least one ovary in this operation are admirable; but I have already pointed out elsewhere that the expected benefits have been over-estimated, and the preservation of ovarian tissue is of value within certain limits. In 1901, Dr. Crewdson Thomas obtained the after-history of 100 patients who had been submitted to hysterectomy for fibroids, and he came to the conclusion that subtotal hysterectomy does not interfere with the sexual passion and that the retention of an ovary is of striking value "in warding off the severity of an artificial menopause," more especially when the patient is æt. below 40; above that age the ovaries decrease in value every year. This enquiry interested me very greatly because many of the patients included in this investigation had been under my own care, and I was so satisfied with the deductions that it became with me a working rule to take unusual pains to preserve at least one ovary in women æt. under 40, but in patients above that age I do not hesitate to remove both ovaries and Fallopian tubes if the removal facilitates the operation, or if these structures do not appear satisfactory and seem in any way likely to give subsequent trouble, because it must be borne in mind that the retention of one or both ovaries is not free from risk. My practice in this matter rests on the following basis: When both ovaries are diseased, I remove them, taking care to distinguish between an œdematous and a diseased ovary. The annoyance caused by flushings is slight compared with the dangers caused by suppuration in a Fallopian tube or in an ovary. I have had an example of each in my own practice, and the facts of each case may be briefly given.

In March, 1898, I performed subtotal hysterectomy on a spinster, æt. 50, on account of a very large interstitial fibroid which caused her to lead a semi-invalid life. Both ovaries and tubes were left and for some weeks after the operation the stump which suppurated gave some trouble and the right Fallopian tube became a pyosalpynx. This I removed in November, 1900. The ovary was large and œdematous, and on microscopic examination seemed to be made up of inflammatory tissue. I found no traces of either ova or follicles. The patient is in excellent health at this date, July, 1906.

The second case is very instructive. In 1906, I removed the uterus from a married lady on account of fibroids which had caused the uterus to become impacted; great pains were taken to preserve both ovaries and tubes. At the time of the operation they were normal in size and shape. The patient did not recover from the operation in the usual satisfactory manner. There was pelvic pain, particularly on the right side, accompanied by a slowly progressive rise of temperature. After six weeks spent in vain temporising, it became necessary to reopen the abdomen, when to my great surprise I extracted an ovary the size of a tennis ball, which had become converted into a sac filled with blue pus, which proved to be sterile in the laboratory. The Fallopian tube had undergone no change. The patient made a tedious but satisfactory recovery.

It must be borne in mind that belated ovaries may become the source of tumours, as in the case of ovaries which have remained in union with a normal uterus; of this condition I have only had one example. I performed vaginal hysterectomy on a single lady, æt. 36, for carcinoma of the body of the uterus; both ovaries and Fallopian tubes were left. She remained in excellent health five years, then a tumour the size of a fist formed in the left half of the pelvis. Cœliotomy was performed and the left ovary was converted into a tumour displaying the microscopic characters of the growth for which hysterectomy had been performed. It was easily removed. The right ovary had atrophied and was represented by a small body the size of a holly berry; the corresponding Fallopian tube appeared as a thin cord attached to it. The patient reported herself in good health three years later. I am unaware of any observations relating to cysts or tumours arising in ovaries which have been left after hysterectomy for fibroids.

Although I have left one or both ovaries in the performance of hysterectomy for fibroids in more than 300 patients, since I advocated the practice in 1897 (see *Trans. Obstet. Society, London*, for 1897), in only two instances have I found anything detrimental in the practice. The last case, however, has led me to consider carefully whether it may not be more judicious to leave only one ovary, and since the beginning of 1906, I have systematically removed one ovary, and find that the immediate good consequences of the operation are in no sense impaired; and in some of the patients I have for greater safety removed the corresponding Fallopian tube.

Those surgeons who have critically studied the conditions of women after hysterectomy are unanimous in the opinion that it is a great advantage to the patient, to say nothing of comfort, to preserve at least one ovary; and I think there is also substantial agreement that whatever good effects follow the practice of leaving ovaries divorced from the uterus in the pelvis they are only temporary, for in the course of a few years the ovarian tissue disappears, and the patients experience the usual symptoms of the menopause like their healthy sisters. I think it possible that the rate of atrophy of the secreting tissue of a belated ovary largely depends on the age at which the patient is submitted to hysterectomy.

My opportunities of learning the fate of such ovaries have happened when patients who have been submitted to hysterectomy have required a second operation for such troubles as appendicitis, or gall-stones, then on the performance of these operations I have taken especial pains to examine the ovaries. On three occasions on which I examined the condition of ovaries conserved in the course of hysterectomy, two three, and five years after the operation, they had shrunk to small nodules about the size of cherry stones, but all these patients had passed their fortieth year at the time the uterus was removed. In April 1899, I removed the uterus and left ovary from a single woman, æt. 29, on account of a growing fibroid. In February, 1905, she again came under my care, and was operated upon for appendicitis. The belated right ovary occupied its normal position at the brim of the pelvis, appearing normal in size and function, for it contained a ripe corpus luteum.

Some writers, particularly Doran, refer to the occurrence of menstruation after subtotal hysterectomy with conservation of one or both ovaries, and in the performance of the operation he has carried out a method (Abel-Zweifel) by which a small segment of the menstrual area of the uterus is left which permits menstruation to be continued in a subdued form. Doran's paper, in the *Trans. Obstet. Society*, 1905, Vol. XLVII., p. 363, is worth perusal, but I cannot express any opinion as to its value as I have never had the courage to try it. My aim in performing hysterectomy for fibroids is to abolish as completely as possible the menstrual area of the uterus, and up to the present my efforts have been successful, and I have no complaint from any patient that this disagreeable phenomenon has manifested itself, although I have been at great pains by my own exertions as well as by the kind efforts of those who have been associated with me in my hospital work to keep in touch with women who have been so unlucky as to require such a serious operation as the removal of the uterus.

The experience which I have gathered as the result of studying the after-effects of hysterectomy in the treatment of uterine fibroids teaches me that in the performance of the operation there are three very important points requiring consideration in women æt. under 40, apart from the main inconveniences which render the operation a necessity, such as hæmorrhage, impaction, sepsis, interference with pregnancy, obstruction to delivery, &c. These three points relate to (*a*) the patient's comfort in securing freedom from flushings; (*b*) if she be married her marital relations; and (*c*) if single, her nubility. These three conditions depend mainly on the conservation of a healthy ovary.

In regard to marital relations, nothing trustworthy is forthcoming, but I believe the retention of an ovary is an additional factor in promoting domestic bliss, and many husbands in giving consent to hysterectomy are particular to insist that some amount of ovarian tissue shall be conserved if possible. The question of nubility is an interesting one. I am able to state that single women who have had subtotal hysterectomy performed with conservation of an ovary have married and lived happily with their husbands, and I am of opinion that the preservation of the vaginal segment of the neck of the uterus is an important factor, as it leaves the vagina intact, and though such women are sterile they are certainly nubile.

I have endeavoured without overstating the case to show that a belated ovary is of high value to a woman æt. under 40, whether she be married or single. In regard to the fate of such ovaries, I think in the present state of knowledge it may be expressed in this way:—In women æt. under 40, a belated ovary remains active and discharges ova.

An ovary belated after the fortieth year rapidly atrophies and menopause symptoms may ensue in the course of a few months after the operation. The retention of the ovary minimises the menopause disturbances, and they are never so acute and prominent under these conditions as they are when an acute menopause is induced artificially.

Up to this point the observations which I have ventured to relate are based mainly on clinical experience, and it is a matter of interest for me to find that they have received experimental confirmation of a remarkable kind. Mr. Bond has published a series of experiments on rabbits performed for the purpose of clearing up some doubtful points in uterine and ovarian physiology (*British Medical Journal*, 1906, 1, p. 121). Among these experiments some bear directly on the subject of this lecture, especially those performed with the object of investigating the effect of removal of the whole uterus on ovarian growth and function. The experimental removal of the whole uterus has no deterrent effect on ovulation, and it does not prevent the occurrence of œstrus and ovulation at periodical recurring intervals.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by R. H. Woods, M.D., F.R.C.S.I., Throat Surgeon to Sir Patrick Dun's Hospital. Subject: "The Treatment of Suppurative Otitis."*

ORIGINAL PAPERS.

ABSTRACT OF THE PRESIDENT'S ADDRESS

Delivered July 30th, at Exeter,

AT THE

ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION.

By HENRY DAVY, M.D., F.R.C.P.

Physician Royal Devon and Exeter Hospital.

SCIENCE IN ITS APPLICATION TO NATIONAL HEALTH.

THE most important function of the medical profession is the practical application of the science of their day to the health and life of the individual, and through him to the community, and our success and usefulness depends on the truth and the value of the knowledge which the science of the day has reached. In earlier times there was very little in the knowledge of the day of which medical men could avail themselves usefully to explain or to combat disease, and the place of true scientific knowledge was occupied by more or less inaccurate theories as to the causes and best way of treatment of various diseases; such theories, for instance, as those of Brown and Rasori, which held that all disease was due to too much or too little stimulation and which lead to bleeding and the abuse of stimulants, in the treatment of disease, that may be observed right down to the time of our last meeting in Exeter. Theories which, as the late Dr. Moxon once said, "were then thought to be the pride of medicine, but which we now consider as at any rate the curse of the patients who were hurried into the next world with the lancet or the brandy bottle on rational principles."

In considering the changes which have taken place in medical knowledge and treatment during these sixty-five years, we have to remember that the knowledge which we use in the profession of medicine is of two kinds—empirical and scientific, using these terms in their highest sense. Each of these systems is of great importance. Much of the best information about disease and many of the most useful plans for its treatment have been handed down to us from remote ages as the product of experience and observation, and are thus truly "empirical," and a large part of the empirical observation of the early Forties is as good to-day as it was then. The knowledge which we call scientific—that gained by systematic experiment and reasoning—is of even more importance; in fact, when founded upon proved truth, it is all-important, and it is the possession of such accurate and true knowledge that distinguishes the medicine of to-day from the medicine of the early Forties.

Much of this accuracy is due to the perfection of the microscope and to the development of organic chemistry, which have enabled us to gain a more or less complete knowledge of the organs of the body and to understand the chemical changes which are constantly taking place in them, both in health and in disease; while it has in some cases also revealed to us the actual germs to which many diseases are due, and the actual toxins which these germs form in the body. These discoveries have entirely reconstructed our knowledge of the various organs of the human body and of their functions, and in the same way they have revolutionised our theories of diseases, of their causes and modes of onset, so that, for the first time in the history of medicine, we are possessed of scientific facts on which to base both theories and practice. And what a gain is this for the profession of medicine in its relation to the public!

We have reached a position with splendid opportunities for usefulness, and a position which will have to be much more definitely recognised by the nation at large if all its advantages are to be fully utilised. It is a position which also carries with it great responsibilities, and we must be careful how we use it. Let us be careful that we teach only what we know to be the truth, avoiding the "premature generalisation" and "rational theories" of the ancients, using both our empirical and our scientific knowledge when necessary, but not attempting to force the acceptance of anything unless it can be demonstrably proved to be true.

The ancient Greeks showed a true appreciation of health when they gave divine honours to Aesculapius, the first physician of the Argonauts, and to his daughter, Hygeia, the Goddess of Health. It would be well if in these days people could be made to understand thoroughly that the cultivation of health is the first necessity of useful lives, and, if they strove to attain it, as the first object of their solicitude; if they recollected that the chief and best asset of a nation is the number of healthy individuals it contains; and if they would also recognise the great principle that no educational system is good which does not aim at producing well-developed, healthy bodies as well as well-trained minds.

Now, in considering all questions of health we have to consider not only the individual patient, but also his environment; meaning by this the sum total of influences which modify and determine the development of his life and character. This question of "environment" has of late years come very much to the front with regard to the question of physical deterioration of the nation as illustrated by the number of would-be recruits for the army who are found to be so physically undeveloped that they do not come up to the requisite standard. It has been carefully and ably dealt with in the report of the Inter-departmental Committee of Physical Degeneration of 1904, a report which ought to be studied by every one who has the health and welfare of the nation at heart.

Time will not allow me to deal very fully with the subject, but I would ask your attention to one or two points, marking them carefully, because they so fully illustrate the scientific teaching which we have gained during the last sixty-five years.

History repeats itself; the first physicians appointed by the authorities of the ancient Greek towns were trained gymnasts from more or less celebrated gymnasia, who treated their patients with regulated diet and regular exercise; and if the English in the twentieth century are to keep themselves free from physical deterioration, our profession must put themselves in the van of a similar movement and show how necessary physical culture and muscular activity are to a nation of "muscular degenerates."

Physical culture is, in my opinion, one of the most pressing questions of the day, for it is by it alone that we have a proper remedy for the state of muscular degeneration which is so prevalent. It ought to be considered by every educational authority, for by its use dwellers in city and country alike can have their muscular systems built up and developed to a healthy standard. There is no need that any collection of children who are not diseased should become a class of muscular degenerates.

For the children of to-day are the men and women who compose the nation of to-morrow, and if they are diseased and physically deteriorated, the nation in the near future will be equally effected. Is it sufficiently recognised how greatly the future of the nation is decided during the school life of its children? It is while the children are at school that you must give them the foundations on which the whole of their future, physical, intellectual, and moral, is to be reared, and if they are not shown how to develop their bodies and keep them in health, the only chance of their learning it has been missed. It is also essential to see that during their school life they are not exposed to contamination from disease, and this can only be done by placing them under the supervision of a trained and qualified medical man, as is done in Japan and in nearly every other country in Europe except England. As the Committee of Physical Deterioration emphatically recommends, every school in the country without exception should be under the supervision of a properly trained medical officer. It should be his duty, with his assistants, to examine every pupil to see who are healthy and who are diseased, who are fit for a course of physical culture and who are not, and generally to look after the health and development of the children. How necessary such medical supervision must be is proved by the fact that Dr. Alfred Greenwood, Medical Officer of Health for Blackburn, in an examination of 388 school children of that town, found that no less than 54 children were affected with some form of tuberculosis, and of this number 34 had tuberculosis of one or both lungs.

I would recommend to the notice of all educational authorities the example of Rugby School and of the scheme originated there by Dr. Dukes, one of the best-recognised authorities on the health of public schools. There every new boy undergoes a carefully-recorded and rather full physical examination, and the games and exercises that he "may play" and "ought to be made to play" are also recorded. But we must go further than this system of games. I quite agree that every boy in every school ought to have a course of physical exercises prescribed for him, adapted to his particular need, and that he should not be allowed to play any game unless he has attained a certain level of muscular development; then we should have a very different condition of affairs from that just revealed. In a public school it would be a point of honour to reach the necessary degree of muscular development to play games, and in the elementary schools the physical exercise would itself develop the muscular tone which is wanted. I would urge on the educational authorities that they are responsible for the development of the pupils' bodies as well as their minds, and that it is of little use to the nation to bring up men with their minds stored with facts but their bodies left ill-developed and generally degenerate.

Next to this question of physical culture, and of equal importance, is the question of the feeding of the people, and it is one of the problems on which we, as teachers of the science of our day, ought to have much to say. "Food," says Dr. Eichholz in his evidence before the Committee, "is the point about which turns the whole problem of degeneracy;" and no one who reads the Report of the Committee on Physical Degeneracy can doubt that the ignorance of people in relation to this matter is truly lamentable. Now, during the last sixty-five years we have gained an immense amount of accurate knowledge with regard to food. We have accurately determined the elements of food and the kind of work which each performs in the system; we know the actual processes by which they are digested, and the part which the various organs take in each process; we have determined the metabolisms they undergo and the excretory products which they form, and how, and by what channels, these products are eliminated. We can estimate the amount of each element required to keep a person in health, and understand the diseased states which are produced by the consumption of too much or too little of the various elements. But, although we have learnt so much about food, I do not think that we have ever yet succeeded in teaching this knowledge in a practical and useful way to the world at large.

We want then, as a profession, to set out clearly, plainly, and shortly the scientific knowledge we have gained, as regards food, in a really practical way that can be understood by the multitude and can be applied to their everyday life; and until this is done I do not see how we can deal with the popular ignorance which prevails on the subject.

It is a sad reflection that we are obliged to appoint a committee to inquire into the physical deterioration of our people when we possess enough knowledge to maintain a very high standard of health if only this knowledge was utilised; and I am glad that this Association is pressing this point on the attention of the Government, and that the views of the deputation which it recently sent seem to have been more or less accepted by the educational authorities.

We shall never be able to deal satisfactorily with physical degeneracy and the prevention of disease so long as the majority of the men and women in the nation remain in absolute ignorance of the very rudiments of science and hygiene. It is not creditable to our educational systems that a so-called "well-educated" gentleman, who may one day be called on to legislate for his country in Parliament, should be able to go through one of our best public schools, and take a degree at one of our oldest universities, without the least knowledge of the composition of the atmosphere, and without the most elementary ideas as to food and hygiene; but so it is, and I despair of improving the health of this country, and of preventing a mass of preventable disease, so long as this anomalous condition of education exists. For in the prevention of disease we as a profession can do little or nothing unless we have the support of public opinion behind us to assist in carrying out the precautions which science shows to be necessary. It is, I think, greatly to our credit that we have accomplished as much as we have in diminishing disease under the present condition of affairs; that we can do little or no more until public opinion is aroused in the matter I will illustrate by asking you to consider the history of pyæmia, typhoid, and tuberculosis. These three diseases have been proved to be caused by the development of certain microparasites which have all been discovered within the last thirty years. Pyæmia and typhoid are, as you know, in the category of diseases which come under the supervision of the Act which deals with infectious diseases, while tuberculosis is not; so that in the latter case we have no means of enforcing the precautions which we know to be necessary.

Now, in the case of pyæmia, the magnificent work done by Lord Lister has shown the world not only the cause of this disease, but the actual precautions by which it may be prevented, the use of these precautions depending on the surgeon and his assistants and on no one else. And so well are these precautions carried out that pyæmia has become almost extinct within these past ten years throughout the civilised world, with a saving of life and misery which cannot be calculated.

Typhoid is also becoming more and more infrequent, and this is generally credited entirely to the improved sanitation and better water supply of the country. But I think these are by no means the chief factors in the case, for there are plenty of insanitary houses still remaining in England and the water supply is too open to the gravest suspicion.

The decline of typhoid fever is largely due to the fact that medical men have done much to destroy it. Its bacilli nowadays are never allowed a chance, at any rate in this country. In every case of the slightest doubt, days before there is any possibility of making a certain diagnosis of typhoid, it is the invariable practice to thoroughly disinfect the patient's stools; and it is to this constant and systematic destruction of its bacteria by disinfectants that, I believe, the diminution of typhoid is chiefly due; and that if these measures of disinfection are continually carried out, this disease will in a few years be as rare as its kindred disease, pyæmia.

Far different is the history when we come to examine tuberculosis, the exact nature of which as an infectious parasitic disease was discovered by Koch twenty-five years ago.

Consumption is an infectious disease in precisely the same manner as is typhoid. In the one you have the bacilli of infection in the sputum, and in the other in the motions, and unless you disinfect them both the infection becomes generally distributed.

Now compare the history of tuberculosis with those of typhoid and pyæmia. I am quite aware that it has decreased under the influence of improved sanitation during the past few years, but yet its prevalence is even now appalling. Approximately, its death-roll in Great Britain is 60,000 persons a year; and Dr. R. W. Philip, of Edinburgh, has shown "that the ascertained mortality from consumption may be safely multiplied by ten in order to represent approximately the number of persons living and already seriously affected at the time, so that Great Britain at the present moment contains 600,000 poor patients with a preventable infectious disease, the large majority of whom are bound slowly to die of an illness which will linger on for from two to five years.

I think it is time that we spoke out the truth about this disease with no uncertain voice; for surely it is time that something was done officially in this matter, and that the attempt to stay the ravages of this terrible disease be no longer left to voluntary associations who must of necessity be unable satisfactorily to deal with a task of such magnitude. Are we to admit that tuberculosis alone amongst the infectious diseases is to have no precautions insisted on with regard to disinfection? Are we for ever to allow consumptives to disseminate their infectious sputum in the streets of our towns; or are we to allow them alone of infectious patients to stay in any hotel or lodging in England without taking any precautions? Nearly every nation in Europe, except England, has awakened to the need of dealing with this disease on scientific lines, and it is time that we followed their example.

I am quite aware of the difficulties which surround the whole question, and I do not wish to put forward my own views as to the measures which are practicable in dealing with the disease. All one-sided statements only tend to obscure the issues and increase the difficulties of the situation. Satisfactory legislation can only be obtained by its careful consideration from many points of view; but is it not time for the the Government to make a careful inquiry into the subject, and that, having obtained the best expert and other opinion available, and having considered the precautions which other countries are taking, they should bring forward legislation to deal with this disease, which yearly destroys nearly 60,000 of our people and brings misfortune and sorrow into some 600,000 homes in our country.

In one of his most striking passages Rudyard Kipling says: "We are a great people and very strong, but we build our empire in a very wasteful way—on the bones of the dead who have died from disease!" It is for our profession, gentlemen, as the advisers of the nation on all matters of health, to show how much of this terrible waste can be prevented; and just in proportion as we succeed in doing this, in that proportion we shall be carrying out the highest purpose of our profession in maintaining the health of the individual and in preventing the degeneration of the nation.

HEADACHES AND THEIR CAUSES.

By Prof. FREDRICH PINELES, M.D.,

Vienna.

[Specially reported for this Journal.]

This is a vague subject, but a common complaint of every-day occurrence, and so complicated in its origin that a lecture devoted to the subject cannot fail to be useful and instructive. A pain in the abdomen, chest, or limbs may be located and relieved at once, but in the head it is more complex and uncertain, though the history may assist us in many cases to make a correct diagnosis. Our first suspicion will be directed toward a pathological change in the brain substance, its coverings, or communicating tracts, the latter having their distribution throughout the body and conveying impulses to the sensitive mass in the encephelon. The brain being the great centre of motion, for the whole body, will affect the whole organism when any morbid change takes place in that organ, and *vice versa*, any pathological change in a distant organ will be reflected on this sensitive centre and may exhibit changes from the long exposure to abnormal excessive stimuli. Headache from this varied origin must be carefully investigated, and every organ of the body minutely examined. The pain in the head may only be a symptom of the disease going on elsewhere, and immediately relieved when the disease is ameliorated or removed.

Among the principal causes of headaches are hyperæmia or anæmia of the brain substance; irritation of the dura mater; and toxines, which adversely influence the vaso-motor centres. Here are a few of the causes whose action we know little of, though vague theories are frequently proffered for acceptance and subsequently disproved by facts.

Let us begin with that form of headache associated with pathological changes in the cranium, including skin, muscle tendon, and periosteum, included under the more common terms of rheumatic, cicatricial, luetic, and nervous parasthesia.

The rheumatic arises in the muscles of the head, and is specially designated as myalgia capitis, and is further specialised as temporalis, frontalis, occipitalis, or galea aponeurotica, according to site. These are usually aggravated by chewing, moving the jaws or any of the facial muscles, as well as by pressure on any of the muscular groups. The pain may be unilateral or bilateral, but it rarely produces trismus which resembles tetanus in its appearance.

There is another form of cephalalgia indistinctly understood by us in Vienna, probably owing to its rarity, but well defined according to Edinger, of Frankfort, and Henschen. It commences with severe pain in the back of the head and down the neck extending to the shoulders, the incidence falling heaviest on females about middle-age and upwards. It is usually preceded by cold and shivering extending over a considerable period. The great peculiarity of this form of cephalalgia is the tubercles, or small nodules, that form in the cellular tissues on the posterior part of the head and down the neck ranging in size from peas to large beans. The nodules form lines across the posterior part of the head, down the neck, and around the mastoid, which have led to the name cicatricial, or band-like headache.

Another peculiar characteristic is the readiness with which this form of headache yields to massage. To show how rare this disease is in Vienna, not a single case has been seen in or out of the hospital during the last twelve months. At the present time it seems to be confined to the north of Germany, where it may be indigenous.

In the maculose, papulose, or later stage of syphilis periostitis is a frequent cause of headache, and as these inflammatory centers usually select the forehead and temporal region, they may be mistaken for other diseases than syphilis. This form of headache forms 28 per cent. of the total met with in Vienna, and should not be lost sight of in all our diagnoses with this as the prominent symptom. It is usually recognised by the patient's description of a tearing or boring pain, increased by pressure over the site, and is intermitting in character, with nocturnal exacerbations, commencing about midnight and lasting two hours very severe, gradually becoming less in the morning. This increase of pain is probably due to some change in the circulation. Immediately the periosteal deposit becomes absorbed, the pain subsides, and the patient is relieved.

The nervous parasthesia is a troublesome form of cephalalgia, affecting every hair follicle of the head, giving pain to the touch; it is usually ushered in by an itching sensation in the scalp, as if some noxious insect were present, while stroking the hair gives pain, though severe pressure gives relief. Closer investigation of these cases reveals some other nervous trouble, of which the headache is but a symptom, of the neurotic, neurasthenic, and the hysteric type; but we may also have the graver affection of hæmicrania and other organic affections of the brain substance. In the neurasthenic, the pain is complained of as a great pressure in the head, although it may be localised to the brow, the temples, or back of the eyes. There are such a variety of symptoms given that careful judgment is required to discern the real seat of lesion. Some will describe the pain as a plank in the forehead, others that a load of lead is bearing the head backwards; but most of them will call it a splitting or wrenching pain. A continuous localised pain usually gives the greatest concern as it reduces the strength and incapacitates the patient for any useful work.

The hysteric headache may last for weeks or months at a time, depriving the patient of sleep or rest, varying in intensity, and locating itself to the brow, parietal, temporal, and occipital regions, resembling in every particular the neurasthenic headache, but the latter is more frequent in the forehead, while the hysteric is usually confined to the parietal region. In the hysterical, the headache has its exacerbations in the parietal region, which is usually described as the clavus hystericus, limited to a narrow area and represented by the patient as a nail driven into the sagittal line of the head, though others may call it a boring or stabbing pain, but all localising it to the sagittal region. Touch or pressure over this area gives great pain, and the skin is usually very hyperæsthetic. This clavus is sometimes associated with general malaise, vomiting and dimness of vision, which may be mistaken for migraine. Another mistake that may arise is where the hysteric headache assumes the form of occipital neuralgia, which begins at the posterior part of the head and extends forward; but the hyperæsthesia or sense of touch may differentiate the two diseases. Again, the occipital headache may be associated with malaise, vomiting, stiffness in the neck and feebleness of the legs, which we recognise as hysteric pseudo-meningitis.

Migraine usually commences in the middle of a disease. It is more frequently unilateral and circumscribed, selecting the eyebrows, the back of the eyeballs, radiating to the upper jaw or settling down in the posterior part of the head and neck. The character of the pain is varied, having the feeling of being situated in the bone or located to the interior part of the brain, and radiating to the cranium, while others describe it as if tearing the head open. It usually lasts from twelve to twenty-four hours, but it sometimes extends over many days. One of its pathognomonic symptoms is the alternate rise and fall of the attack, the succeeding attack always appearing before the preceding one has disappeared, which produces the status hæmicranicus. It is usually hereditary, and attacks the young and may be assumed to depend upon some morbid condition of the central system. The diagnosis and prognosis of this disease is a difficult but important factor in the treatment, as tumours or other growths may be the remote cause of the pain. When a cerebral tumour is present, vomiting without relief and at very short intervals is usually present. The patient is apathetic though the sensorium may be normal and where tabes is present the progressive paralysis soon declares itself. Another differential diagnostic sign would be the hereditary family weakness commencing in young persons as idiopathic migraine, but subsequently diffusing itself as a general headache and yielding to syphilitic treatment. When individual symptoms of epilepsy and hæmicrania are present, it will be difficult to decide the origin. It is usual in these cases to observe the presence of cramp for deciding on epilepsy, which may be present in the tongue or some of the facial muscles.

The most important change in the central system, when there is a neoplasm is a constant headache. The great characteristic is the severe pain, which is intense and constant, causing the patient to despair of relief. The character of the pain in tumours of the brain is for the most part diffuse and not localised, although it is dangerous to lay this down as a rule as many of the tumours give rise to localised pain which moves from place to place and cannot properly be localised. When the pain is confined to the posterior part of the head and neck, it is possible to locate the growth to the cerebellum; where it radiates down the dorsal region to the arms, we may be able to diagnose the neoplasm to be located in the tentorium.

If the pain be located in the anterior part of the head the neoplasm may be suspected near that site, but this is always a very dangerous conclusion, as many of these tumours radiate widely and are far removed from the site of pain. For instance, any irritation in the dura mater may act on some of the branches of the trigeminus, which might be considered the vehicle of pain, and thus lead to a false diagnosis of the case.

Another common headache is associated with meningitis in all its different forms and degrees. In lepto-meningitis it is an early symptom, and appears with unerring constancy.

Syphilitic headache is the early stage of basilar meningitis. It commences with great severity with nocturnal exacerbations about the same hour every night, and passes off on the following morning at the same time as on the previous day. It is diffuse in character, but locates itself within the cranium. This form of headache commences early in the disease and may continue for months or years.

In contrast to syphilitic basilar meningitis comes the convex meningitis or the meningitis of the upper vault of the cerebrum. Here the pain is not so constant as in the basilar form, although it is more circumscribed both by pressure and percussion. The primary syphilitic arteritis is the probable cause of the pain, which is not so severe or protracted as the basilar form.

Cerebral abscesses cause the pain to be constant and well localised in one hemisphere or the other. If the abscess be due to otitis media, the pain will be located in the temporal or occipital region.

Besides these more important causes, there yet remain a few minor sources of headache, all more or less affecting the brain indirectly, and producing severe pain. Diseases of the nose and its proximate cavities, such as chronic rhinitis, adenoid vegetations, hypertrophy of the turbinate bones, septum deviation, polypi, fibroma, &c. The pains associated with these are varied and of different intensities, and are described as boring, stabbing, tearing, and crushing, appearing over any part of the cranium. The chronic form of any of these diseases may set up empyæma, with acute exacerbations, by checking secretions, producing congestion or preventing the easy flow of secretions along natural channels. Empyæma may be induced by over-exerting the corporal and psychical functions as well as the intemperate use of alcohol and tobacco, which must be carefully differentiated from the above for treatment.

Frontal sinus changes may produce intractable supra-orbital neuralgia, recurring daily at particular periods, but the character of the headache in these cases is so different that no clear description can be given. All are more or less diffuse and ill-defined about

the forehead, and may arise from the maxillary sinus, ethmoid or sphenoid cells as well as the frontal sinus. Morbid changes in these centres not infrequently cause pain in the occipital, parietal, and temporal regions, as well as in the forehead, and have no fixed character. Teeth, again, particularly carious teeth, cause pain in the temporal region, which disappears rapidly on extraction.

The anæmic headache is well known to every practitioner. The chlorotic girl, the parturient exhausted mother, the female suffering from some chronic genital trouble, or the over-worked student, accountant, and teacher, are well known examples of sufferers from this malady.

The toxic headaches form another extensive class. These are often divided into exogenic and endogenic, which is not a very scientific arrangement, as all exogens taken soon become endogens. The former comprehend alcohol, nicotine, mercury, &c., while the latter are well represented by the toxines of fevers, infections from abscesses, the abscess of lungs in tuberculosis, constipation, arterio-sclerosis, &c. These have no particular symptom or site that can distinguish them from any of the other causes; the general condition of the body must be the guide. There is one of these toxines, uræmia, that deserves special note in the diagnosis; it can be defined as a piercing, pressing pain in the forehead though sometimes met with in the occiput. It may be continuous for days or recur hourly for some time.

A pathognomonic symptom in uræmia is that the headache may continue days and weeks accompanied with sickness, and vomiting unconnected with error of diet, and defying every drug in the pharmacopœia

Headache from disturbance in the alimentary canal is often complex and difficult of solution from its close connection with errors in diet, nervous dyspepsia, or neurasthenia with atony of the digestive tract. We have already referred to people who suffer from severe headache, of which constipation alone is the cause, and when this is relieved the headache disappears. This is a plausible explanation, as the accumulation of fæces presses on the surrounding vessels and diaphragm, disturbing the vascular system and deranging the reflex action and this finally affects the cerebral circulation, and in consequence headache supervenes. There is another source of headache in the ptomains that are liberated in sulphurous media.

The arterio-sclerotic suffer from severe headache owing to the disturbance in the circulation as well as that toxic products are liberated and thrown into the circulation.

It may seem strange that the genital organs should produce headache, but gynæcologists record cases where a displaced uterus has kept up headache for months without relief till the displacement was corrected, when the headache was instantly cured.

The eyesight is a well-known cause of headache; even in children this complaint is not unknown, arising from some refractive anomaly, insufficiency of the internal muscles, or enfeebled accommodation. A holiday for such children promptly cures the headache, which is characteristic in this form.

Cephalæa adolescentium is common to both sexes about the sixteenth or eighteenth year, it is relieved at night, but recurs on waking, and locates itself to the forehead. The youth is dull, weak, and unable for duty without great effort. This is an obscure form, and attributed by many authors to the development of the generative organs; others, to masturbation or abuse. The lecturer related other cases coming under his personal notice where the father had been a "Potator," while the mother suffered from hæmicrania, which suggested to his mind a constitutional origin for the cephalalgia.

Vasomotor disturbance is another fruitful source of headache and generally due to a congested state of the vessels which may arise from a variety of functional disorders.

A general rule for the diagnosis of headache is to first examine the nose, ears, eyes, and urine, and, on nothing being found to explain the cause, the duration is the next point to investigate.

If the headache be of recent origin, it may confirm the suspicion of neurosis, affections of the nose, otitis media, meningitis, teeth, or uræmia. On the other hand, if the duration be long, covering four or eight weeks, constipation, lues cerebri, uræmia, arterio-sclerosis, periostitis, or tumour may be the cause.

The therapy of this diverse disease cannot be confined to any particular line, but must be directed towards removing the cause. In the neurotic the patient should be supplied on waking with a little milk, chocolate, or fruit; never leaving the bed in a fasting condition. Many of these patients require a little food every two or three hours, and when engaged in outdoor work should carry small biscuits or such-like for the occasion. Against the localised pain in the head, a 10 per cent. menthol ointment may relieve it if applied twice a day. Vibratory massage sometimes acts favourably, but cold douches increase the pain. When the pain in the head is diffuse, high elevations, rest from work, or the "Winter Kur" will be found most beneficial, especially in hysterical cases.

In severe migraine cases, the diet should be strictly vegetarian, and free from every form of alcohol. The bromides must be given freely, from 2 to 3 grammes, or 30 to 50 grs. a day for six or twelve months, with 5 or 10 mimims of an arsenical solution. In addition to this, many cases require a gramme of sodium salicylate or aspirin recently introduced. Some obtain good results from antipyrin (0.5 to 1.0 grm), phenacetin (0.5 grm), migrainin (1.1 grm), pyramidon (0.5 to 0.75 grm), caffein (0.2 to 0.4 grm), &c.; but the necessity of the case may require a variety in the protracted course. The adjuncts are quiet, thermaphor, warm foot-baths, and, only in very severe cases is morphia admissible. In the hemicrania permanens, residence at great altitudes gives most relief.

Headache in children improves with hygienic attention, never allowing them to go fasting to school. In many cases a good breakfast will dispel all headache, but hot schools or badly ventilated class-rooms, with imperfect, or too strong light, may be the sole cause of the trouble. The medicine should be bromide of potassium, arsenic, and bathing the body with water at summer heat.

It only remains to consider the cicatricial or glandular headache of which we have little experience in Vienna. Our nothern colleagues prescribe sudorifics, sodium salicylate, or aspirin, thermaphor and massage. For the adolescent form, arsenic, iron, country air, with a generous diet of milk or fruit. Those in whom syphilis is suspected mercury, iodides, &c. In uræmic cases, laxatives, sudorifics, and caffein subcutaneously are useful.

SUGGESTED IMPROVEMENTS IN THE NOTIFICATION OF DISEASES. (a)

By J. C. McWALTER, M.A., M.D., D.P.H., F.F.P. & S. (GLAS.)

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MUNICIPALITIES are concerned with the interests of mankind in the mass, and not as individuals—with the series or class and not with the mere units. Obviously the good of citizens at large is of greater moment than the ease or the privacy of individuals, and no private person is entitled to any right or privilege which materially interferes with the interests of society.

Therefore the interests of society demand that public notice be taken of the diseases from which individuals suffer—not from mere caprice or curiosity, but in order that they may be stamped out—the private individual cannot be heard to say that his privacy is invaded, or his rights trampled on. No people were so conservative of their rights as the ancient Romans, and none were so little disposed to pander to the prejudices of others; but the maxim of their law still prevails that we may use our advantages only when they do not injure others.

(a) Paper read at the Congress of the Royal Institute of Public Health held at Douglas, July, 1907.

The law requires the medical practitioner, under pain of penalty, to apprise the Public Health Authorities when cases of certain contagious diseases come under his notice. This is an apparent invasion of the rights and privacies of his patient, and an apparent breach of the confidence placed in the physician. But public opinion has long since sanctioned it, and the most lordly person recognises that his convenience must make obeisance to the public good.

The question which now arises for consideration is whether the principle of notification of diseases should not be extended far beyond the few infectious diseases in respect of which notification prevails. Is it worth while having the vast machinery of notification only that we may hear of a few cases of typhoid or scarlatina or diphtheria? A tendency now prevails among medical officers of health to look on zymotic diseases as the only ones which they can be expected to check, and if they can point to a diminution in the death-rate from zymotic diseases, to claim that they have fulfilled their functions.

This is one of those fallacies which are the opprobrium of medicine; one of those half-truths which have led scientific men into absurdities which persons of ordinary common sense should except. There appears to be a painful absence of the logical mind amongst the faculty which leads them to advocate measures of which the consequences have not been calculated or the effects foreseen. Thus we have gone to expense and brought on odium by our efforts to have every case of scarlatina notified. We were then forced to hold that our duty was to prevent the spread of the contagion, and hence we removed the patient to a hospital built at great expense. One consequence of this is that patients who think their children have scarlatina carefully avoid calling in the doctor, and another consequence is that when the patients are brought together in hospital the gravest case infects the lightest and the mortality and sequelæ are far beyond those of cases treated at home; whilst the length of stay and the resultant expense have been so great on municipalities compared with the trifling benefits, that doctors have fallen into great disrepute. Further, the fact remains that scarlatina has become of so mild a type that the mortality of untreated cases is but slight. Quite different has been our action with regard to measles and whooping-cough. Many municipalities paid at one time for the notification of these diseases, but the expense became so great, and the impossibility of making hospital provision so obvious that few authorities made any attempt to treat them.

We have then, an elaborate system of notification of disease carried out on the theory that contagious diseases being preventible should be prevented and that the adequate means of prevention are isolation and disinfection. We have also the anomalous position that out of the small number of infectious diseases prevalent in Britain, those which are amongst the most contagious and the most fatal—whooping-cough and measles—are, in most cities, not notifiable, and even when notified no adequate attempt is made to segregate them. Of the remaining diseases notifiable as infectious, scarlatina, diphtheria, and enteric are so liable to be confounded with other diseases that many practitioners hesitate to diagnose a disease as scarlatina, typhoid, or diphtheria until it has become so unmistakable that much danger from contagion has already occurred. The recent outcry in the press about the figures so unwisely published by the London Metropolitan Asylums Board—where it was shown that some 20 per cent. of cases were inaccurately diagnosed—has made the public much more critical about practitioners generally, and much more prone to proceed to law if the practitioner does not exhibit more than human sagacity in foreseeing the development of a disease. It is also to be feared that a recent decision in the High Court of Ireland—where it was laid down that the skill and care which the practitioner should exhibit must extend to the foreseeing of and the foreguarding against the unexpected results of his treatment—might induce a judge to hold with a litigant who contended that the fact of a doctor having made a mistaken diagnosis of a disease was *prima facie* evidence of negligence which the practitioner must suffer for unless he can completely misprove.

It becomes, then, under modern conditions, a very grave matter for the physician to diagnose a case as one of notifiable infectious disease. The patient and his household have a relation to society which is immediately altered in a very unpleasant fashion by the diagnosis. If it be a child at school, it must be kept away for several weeks, the other children in the house must be kept away, and the school authorities are indignant at the implied slight on the school. If it be a man or woman in a factory or large business place they, with those in the house, will scarcely be permitted to attend work. A species of interdict is placed over the place, and everyone's hand is against the unfortunate doctor who gave the notice. Afterwards the sanitary authority comes to disinfect—often with little tact—and if it be a public shop or other place of resort, it may be ruined by the suspicion of sickness. We have all had experience of this, and all this disturbance of society is due to the expression of opinion of a medical man who himself knows that the evidence on which he bases his view is far from being conclusive

Thus a practitioner is put in peril of a lawsuit every time that he reports a case, and every time that he neglects to do so he is liable to a fine. The benefit of the system to the public health is altogether illusory, because although the spread of an epidemic may be checked in a few instances, in many more people who suspect an infectious disease are careful not to call in a doctor, lest he should report them, and it is practically impossible to bring those people under the law, first, because they are not found out, and, secondly, because if they were they would probably escape on the plea that they did not know what the disease was. I have known dairy keepers to have children with scarlatina, and, suspecting the disorder, to bring the child out to a doctor; when he stated the nature of the disease they simply refused to give their address, and nursed the child probably at the back of the shop. To such an extent has this feeling grown that all such people have now simply a horror of bringing a doctor to their place, and will do anything to avoid it.

The sanitary authority, I submit, cannot do much to check the ravages of disease until it is accurately informed of what diseases exist in its midst. It has now no means of knowing except in the case of a few infectious diseases, unless from the Registrar-General's returns. But these returns necessarily come too late, and they deal only with the immediate cause of death. Each of us may suffer a hundred ailments, possibly preventible and certainly discomforting, but we shall augment only one item in the Registrar-General's mortality list, and that surely will give an inadequate account of our clinical history.

I submit that a far more satisfactory mode of notification of disease would be if the sanitary authorities got from each practitioner in the district an account each week of the diseases which he had treated. Something like this is done in the Poor-law system, each person's ailment is noted and the presence of any particular disease can be seen at once; but I do not know that any special statistical use is made of those lists of affections. If the practitioners were furnished with lists containing the usual heading of diseases—as of fevers, influenza, whooping-cough, dysentery, syphilis, gonorrhœa, septicæmia, pneumonia, phagedæna, tuberculous and parasitic diseases, rickets, anæmia, alcoholism, &c., he could fill up the particulars in a few minutes; and if a small fee were forthcoming for punctual attention, the medical officer of health would have a clinical picture of the state of health in his district every week, and could at once cope with the more prevalent diseases.

The suggestion, then, is that the notification system should be extended to diseases of every class, but that the individual names be not disclosed except where already required. Thus much valuable information about venereal diseases, abortions, alcoholism, and several other important social factors can be obtained which practically make no show on the Registrar-General's returns.

This system prevails already, I understand, in many important cities. Thus even so far away as Buenos Ayres a weekly return can be had, in English or Spanish, of every case of disease treated in the city, and at a glance one can see that type of ailment which needs attention most, and is wreaking most havoc.

It is an established axiom in preventive medicine that the petty meddling of the private practitioner, however individually able, can do nothing to lower a death-rate. This is the task of a sanitary authority having extensive powers and an able staff. But those powers and the efforts of the staff are often rendered futile because they have no adequate means of becoming aware of the state of public health at any given moment, their only means of information being a few notifications of some of the infectious diseases and the mortality returns. Obviously, either of these, or even both of them, is inadequate to give such a picture of the amount of sickness in a locality at any moment that effective steps can be taken to check it. The mortality statistics of the Registrar-General are prepared at enormous expense, and the notification of infectious diseases also causes great expenditure, but we consider the money well spent if it enables us to grapple the better with disease. A necessary complement of these returns is that we should have a means of knowing, week by week, what diseases were prevalent, whether infectious, or fatal or not. These would be, on a general scale like the hospital statistics which have proved of such service; but hospital statistics are vitiated by the fallacy of being true only of a picked class and under special circumstances.

It must be insisted on that the disclosure of the class and kind of disease which a physician is treating involves no breach of confidence; there is no need to give the names of the parties suffering; it suffices to have something like an accurate account of the number of cases of a disease in order to show its prevalence. It will also probably have a healthful effect on certain practitioners that they would be forced to make a definite diagnosis; we are all prone to a non-committal attitude as to diagnosis, which induces slovenliness of treatment, and, therefore, needs correction.

In brief, the improvement in the notification of diseases which I have to suggest is, that *all* diseases be notified to the sanitary authorities at regular intervals, and that a small fee be paid to the practitioner for his trouble. Thus the sanitary authorities become at once cognizant of all the forms of disease which exist in their locality, and can take steps to check their progress.

ANTI-PUTRESCENT MEDICATION BY SPECIALLY-SELECTED LACTIC ORGANISMS,

WITH REMARKS ON

MUCO-MEMBRANOUS ENTERO-COLITIS.

By M. DUTOUR, M.D.,
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[SPECIALLY TRANSLATED FOR THIS JOURNAL.]

THE biological researches of Professor Metchnikoff and his followers have not only served the purpose of calling attention to the dangers of intestinal putrefaction, but they have indicated the lines on which they may be fought.

The remedy is not to be found in mineral chemical agents but in the domain of bacteriology. We must destroy the putrefactive agents by other varieties of micro-organism, carefully chosen so as to obtain them in a state of absolute purity, taking care also to prefer varieties which produce large quantities of lactic acid so that the latter, being produced in a nascent condition within the organism, may bring about antisepsis and effect a salutary change in the humours.

According to Metchnikoff and his school we must combat the deleterious microbes of putrefaction by the aid of judiciously-selected lactic microbes. The latter, however, must fulfil certain conditions so that in practice we may not be exposed to the drawbacks inherent to kephyr and yaourt as these not infrequently comprise organisms injurious to the human economy which determine abnormal alcoholic fermentations.

Researches carried out on these lines at the Paris *Institut Pasteur*, in which the Bulgarian bacillus which is a powerful producer of lactic acid, was associated with certain selected paralactic microbes, resulted in a combination that exerts a most remarkable anti-putrescent action, and which is perfectly harmless, viz., lacto-bacilline, now commonly employed in contemporary therapeutices.

This remedy must therefore be taken to represent the outcome of a long series of investigations undertaken by Professor Metchnikoff's pupils, and we must emphasize the fact that it represents especially "the superior action of the Bulgarian bacillus without the least trace of abnormal fermentations" (see Etudes sur La Nature Humaine. Paris, 1906; Essais Optimistes, Paris, 1907).

It is necessary on the present occasion to recall the physiological investigations on lacto-bacilline. Bertrand and Weisweiller demonstrated the fact that, alone among the lactic ferments, the Bulgarian bacillus elaborated from 25 to 30 grammes of lactic acid, transforming into this substance the whole of the milk sugar. M. Belonowsky, quoted by Metchnikoff, showed that mice which were subjected to the action of this bacillus thrived better and were more prolific than the others and that at the same time all fœtor disappeared from their dejections.

We will not insist on the protective influence which the authors of this treatment attribute to it as predisposing to longevity. Following Metchnikoff, who dwelt particularly on the absolutely hygienic part played by lactic ferments, Maurice de Fleury in his turn drew attention to the prophylactic, *i.e.*, curative, action of these organisms (*see* Annales of the Institut Pasteur, No. 12, 1906; Essais Optimistes, pp. 221, 222; Quelques Conseils pour Devenir Vieux. Paris, 1907).

On the present occasion we are more particularly interested in the clinical effects that may reasonably be anticipated from this substance, and our object is to bring to the notice of practitioners the results that we have obtained in the treatment of seven cases of muco-membranous entero-colitis.

To begin with we must be careful to enjoin the consumption of a sufficient quantity of sugar whenever we propose to employ the ferment treatment. Sugar, in fact, constitutes the indispensable food of these protective microbes, and it is from sugar that they elaborate the lactic acid. A suitable dietary must also be imposed, indeed, the patient must become vegetarian or semi-vegetarian for, in spite of Cohendy's statement that the anti-putrescent action of lacto-bacilline is manifested independently of all dietetic restrictions, if we wish to obtain immediate results we must avoid introducing into the intestine alimentary substances which are peculiarly prone to decomposition (Comptes Rendus de la Société de Biologie, No. 13, 1906).

Of the four therapeutical forms in which lacto-bacilline is presented—curdled milk, peptonised bouillon, a powder, and tablets; the last two were principally employed by us in the following doses: half a tube of powder in the twenty-four hours, in two parts, given at the end of the two principal meals; three or four 30cg. tablets daily, as above, associated in both instances with the ingestion of some sugar-containing food.

The results of this treatment were produced in very short time. Beginning with diminution of the diarrhœa and the pain, the fœtor of the stools was diminished in a marked degree. In some instances, however, there is an initial phase of constipation, but this never lasts long and need not be taken into account.

As a rule, in the course of a fortnight, the glairiness disappeared, and although the elimination of false membranes persisted somewhat longer they were rarely present after a month's treatment, whereupon all the symptoms of entero-colitis subsided.

In two instances there were acute exacerbations accompanied by a good deal of pain. On palpation the colon could be felt to be spasmodically contracted and the diarrhœa was obstinate and extremely fœtid. In these cases we had recourse to the peptonised bouillon, two wineglassfuls daily, the patient being placed on a rigid diet wilh daily irrigation of the bowel. In both cases the acute attack subsided within a week.

It is obvious that the peptonised lacto-bacilline bouillon exerts very rapid effects, and is better adapted for the treatment of acute cases than the tablets, but in chronic affections the tablets are preferable and, moreover, they are easier to make use of.

In our opinion the complete cure of old-standing cases of entero-colitis, which took place in about six weeks on an average, can only be explained by a salutary modification of the microbial contents of the intestine. It is, however, possible that some share in the effects must be credited to the hyper-secretory influence on the liver which most authors ascribe to lacto-bacilline. However this may be, many observers have noted this curative action, among others, Combe, of Lausanne, Brochet, Jeanselme, Rodenthal, Nigoul, Gottschalk, etc., who have all published cases in which favourable effects were noted.

All the other manifestations of intestinal decomposition appeared to be improved by this lactic ferment. We have given it in the treatment of infantile diarrhœa, constipation and ordinary colitis, as well as in the tuberculous form when the patients were anæmic. Such patients do better on curdled milk, which possesses remarkable nutritive properties, in virtue of the solubility of its caseine and phosphates.

To sum up, in combating intestinal putrefaction and especially in the treatment of chronic enteritis nothing has appeared to us to give as good results as lacto-bacilline. In any event our personal experience enables us to state that in the last-named affection lacto-bacilline appeared to act more energetically than any treatment previously employed. As to the influence of the Bulgarian bacillus with paralactic bacilli in the prophylaxis of senility and arterio-sclerosis we are not at present in a position to make any statement, but we do affirm without hesitation its clearly curative action in enteric troubles and its absolute innocuousness.

CLINICAL RECORDS.

MALIGNANT DISEASE OF OVARIES AND VERMIFORM APPENDIX OCCURRING IN A PATIENT, AGED 69. (a)

By J. H. Swanton, M.D., M.Ch.

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The patient, A. J., from whom these tumours were removed, was a married woman, æt. 69, who was engaged in domestic work. She came to hospital in January, 1907, complaining of dysuria and a slight red vaginal discharge. The only previous illness was influenza, of which she had several attacks.

Her menstrual history presented no unusual deviation, and the menopause occurred more than fifteen years ago without any complication. Although she had been pregnant nine times, only three children were living; there had been two premature births, one stillbirth, and several miscarriages before the birth of the last child. The youngest living was æt. 30, and the eldest 35.

Her present illness began in July, 1906, with a scanty blood-stained vaginal discharge. In November, 1906, there was incontinence of urine and a consciousness of failing strength, but there was no pain.

The patient was well-nourished for her time of life. The mammæ were atrophied. The abdominal wall was distended and resonant, but the veins in the lower portion were distended. On deep palpation a tumour was felt low down in the true pelvis, situated centrally and fixed.

The vulvar outlet was relaxed and the vagina atrophic. The uterus was enlarged and directed forwards, but moved with the mass situated posteriorly.

The utero-rectal pouch was occupied by an irregular mass firmly fixed in the pelvis, and extending towards the lateral walls. On rectal examination the tumour was found to extend laterally, but the upper limit could not be reached.

The diagnosis was that of a uterine fibroid undergoing malignant degeneration.

The radial arteries were thickened, the pulse infrequent and intermittent. A basic systolic bruit was heard over the præcordial region. Early in March, 1907, she had an attack of bronchitis. When seen again, the growth was found to have increased towards the left side and was obvious on inspection of her abdomen. Her stools were frequent, liquid, and defæcation was painful. There was œdema of her left foot. At the end of March, 1907, she was admitted into hospital, when the greatest abdominal circumference was 82 ins., the distance from the right anterior spine of the ilium to umbilicus was 6 ins., and the corresponding measurement on the left side was 6½ ins.; from upper margin of symphysis pubis to umbilicus, 6 ins. The upper limit of the growth was 4 ins. above the symphysis.

The upper part of the growth was irregular and some limited fluctuation was felt on the left side. There was some free fluid in the abdomen and palpation caused pain. On vaginal examination the growth was found almost on the pelvic floor; the external os was behind the symphysis and a blood-clot was found extruding. Early in April, 1907, I performed abdominal cœliotomy by a median vertical incision, when about one pint of ascitic fluid came away; the great omentum was adherent to the tumour occupying the pelvis.

After separating the adherent omentum, two tumours partly cystic and partly solid, were found filling the pelvis, firmly adherent to the surrounding structures, but more so on the left than the right side. The uterus was 4 ins. in length, hyperæmic, and slightly attached to the tumour on the left side by a whitish band, which was easily broken down. The adnexa could not be identified on either side.

The tumours were in contact in the cavity of the pelvis, and each consisted of a solid and cystic portion. After separating all adhesions, the tumours were lifted out, the pedicles ligatured and removed. On making an examination of the vermiform appendix, the meso-appendix was puckered in one part and the consistence of the adjacent wall increased so as to necessitate removal.

There was little hæmorrhage throughout the operation. The abdominal wall was closed by a continuous cat-gut suture for the peritoneum, and interrupted silkworm gut sutures for the muscles, fasciæ, and skin. The temperature rose on one occasion to 104°, but fell to 99° within twenty-four hours. After the fifth day, the stools became frequent and loose for three days, and then were passed once daily afterwards.

The tumour on the left side was 6½ ins. in length and 2½ ins. in width. The surface was irregular, of dusky hue, and covered with tags of tissue. On section, numerous cysts were found in the periphery containing a limpid reddish fluid. The central portion was mottled, white and red, with processes radiating out towards the cystic portion. The tumour on the right was 4½ ins. by 4¾ ins., and presented a more irregular surface, while the cysts were larger and situated inferiorly. The internal structure was similar to that on the left side. The vermiform appendix was situated mesially to the cæcum, directed obliquely upwards to the left, and 3 ins. in length.

(a) Read before the British Gynæcological Society, July 11th, 1907.

On microscopical section, after staining with hæmatoxylin and eosin, the growth was seen to consist of oval spaces lined with several layers of columnar cells passing through the basement membrane in some places, and encroaching upon the lumen. These cells were in different stages of degeneration. In some of the spaces a colloid material was found occupying the central portion, and in these the layers of lining cells were not so numerous. The interstitial tissue consisted of connective tissue undergoing hyaline degeneration, with many polymorphonuclear cells scattered throughout it.

A transverse section of the appendix showed the same variety of growth invading the muscular layer and passing in towards the submucous. This growth in the appendix probably arose by implantation rather than by metastasis from the original. The genesis of this growth would appear to have been from a previous cystic condition of the ovaries, which became the seat of malignant degeneration after the menopause. The patient was discharged on the twenty-fourth day after admission, and the last report was that she had resumed her domestic duties and had developed a ravenous appetite. There is, however, little prospect of ultimate recovery, as this type of growth is particularly malignant.

THE OUT-PATIENTS' ROOM.

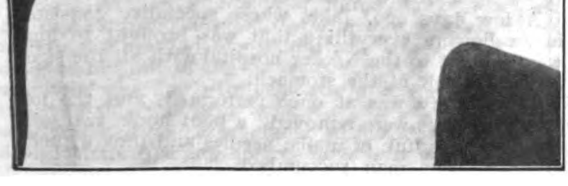
GREAT NORTHERN CENTRAL HOSPITAL.

Congenital Elevation of the Scapula (Sprengel's Deformity).

By Arthur Edmunds, B.Sc.Lond., M.S., F.R.C.S.

Among the out-patients was a woman, æt. about 50' who came complaining that she had swallowed a threepenny-bit. There were no obstructive symptoms, and there was no evidence of any impaction of a coin in the œsophagus. The patient was obviously extremely hysterical—indeed, almost melancholic; but in the course of the examination it was discovered that she was suffering from the deformity of the scapula first described by Sprengel, and named by him Congenital Elevation of the Shoulder.

The condition had never inconvenienced the patient in the slightest degree, but on examination it was seen that the right shoulder was considerably higher than the left. The upper border of the scapula could be felt from the front apparently as a projection forward of this part of the bone. Extending from the upper part of the scapula to the occipital region was a thick mass of muscle composed mainly of the upper fibres of the trapezius. This mass of muscular tissue was not only thicker but denser than normal, as if a considerable portion of the muscular fibre had been converted into fibrous tissue. Below the scapula the muscles of the back were not very markedly affected, and the inferior angle of the scapula did not project much beyond the one on the opposite side. Movements at the shoulder-joint were quite normal, but the movements of the scapula upon the trunk were distinctly limited, the patient being unable to raise the arm above the right angle, and it was easy to make out that further progress was prevented by the superior angle of the scapula impinging upon the cervical spine. This point was confirmed by a skiagram. Mr. Edmunds remarked that this condition was comparatively rare and that although many cases had been described in children, very few had been described in adults, and the present case was valuable and interesting as showing the ultimate condition of this deformity. The causation of the deformity has not been definitely settled, but it is extremely significant that a large number of the cases have been born with a posterior displacement of the arm. As many of these intrauterine displacements are present comparatively early and are maintained by a deficiency in the liquor amnii, it is very probable that they play an important part in the production of deformities. Another explanation is that the muscles connected with the lower portions of the scapula, namely, the rhomboids and the inferior fibres of the trapezius, are atrophied, allowing the upper muscular fibres to pull the scapula upwards. The fact, however, that some of these cases show a scapula which resembles in shape the type of bone found in the ungulata (sheep and oxen) in which the long axis of the bone is parallel to the spinous process, the supra-and infra-spinous fossæ being almost equal in size, suggests that some developmental error is also present.



These animals also possess a large supra-scapula and in some cases of Sprengel's deformity a well-developed bone is found extending from the superior angle of the scapula to the spine, possibly representing a suprascapula. In the present case there was no bone of this description present, and the scapula was normal as regards shape and size. The hooked condition of the upper border of the scapula which could be felt above the first rib was due merely to the position of the scapula, which, as it is drawn upwards, rides forwards over the curve of the upper end of the thorax.

Treatment in these cases is not very satisfactory; any attempt to divide the muscles and bring the scapula into line with the opposite side should not be attempted, the muscles being usually so contracted and sclerosed that an extensive operation would be necessary. Even if this could be satisfactorily accomplished the weakness of the opposing muscles would lead to a recurrence of the deformity. If a suprascapular bone be present it should be removed and some cases have been benefited by removal of the upper angles of the scapula, allowing the arm to be raised above the right angle.

OPERATING THEATRES.

WESTMINSTER HOSPITAL.

Nerve Transplantation for Paralytic Talipes Calcaneus.—Mr. A. H. Tubby operated on a case of talipes calcaneus due to infantile paralysis. The patient was a child, æt. 5 years, who had attacks of infantile paralysis in infancy affecting the right leg. A large measure of recovery had taken place but there was considerable loss of power in the gastrocnemius and soleus. On examining the movement of the foot it was found that the child was unable to plantar-flex or point the foot fully. The ankle could not be extended beyond a right angle. By electrical test it was noted that the muscles reacted to faradism, but reaction to galvanism was feeble, thus showing the degeneration of a considerable portion of the fibres of the large calf muscles. The child had been in the hospital for seven weeks, during which time massage and electrical treatment had been assiduously carried out, but no improvement had taken place. Photographs were shown indicating the range of movements at the ankle. Mr. Tubby pointed out that the nervous supply to the gastrocnemius and the soleus is by two branches of the internal popliteal, one nerve passes to the outer head of the gastrocnemius and the other nerve to the inner head of the same muscle and supplies also the soleus. These branches have a fairly long course and can be separated for some distance up the main trunk without interfering with the remainder of the nerve fibres in it. The child having been duly prepared and every precaution taken, inasmuch as one of the main features of success in these operations is to obtain primary union, a vertical incision three inches long was made in the middle of the popliteal space, and the internal and external popliteal nerve trunks were defined. By a little careful dissection the nerves passing to the gastrocnemius and soleus were found and isolated; sterilisable electrodes were then used for stimulating these nerves and their identity confirmed. Finding that contraction of the affected muscles followed stimulation the next steps of the operation were proceeded with. The length of nerves required to bridge the distance between the internal and external popliteal nerves was estimated, and just below the points of intended division a strand of the finest sterilised gut was passed through the nerves These were then divided from their origin at the internal popliteal. The next step was to prepare the external popliteal for the reception of the nerves to be transferred. In doing these operations Mr. Tubby said the best instruments were fine tenotomy knives and forceps, such as are used in ophthalmic surgery. Care must be taken not to nip the nerve trunks with forceps under any circumstances. A small vertical incision was made with a tenotomy knife through the epineurium of the external popliteal nerve in two places until white matter began to exude. The nerves to be transplanted were then brought across to these incisions and their proximal ends inserted and secured by the strand of gut previously passed through the nerves. The greatest care was taken to see that the tips of the transferred nerves were actually imbedded in the external popliteal trunk. The external wound was then closed and the limb put on a splint. Mr. Tubby remarked that previous experience of two similar cases operated on by him, and shown at the Clinical Society last session, had proved that this operation was a satisfactory one and was justifiably undertaken when ordinary measures, such as massage and electricity, had failed. In one of the cases a partial recovery of power in the gastrocnemius and soleus had taken place, and in the other case the recovery was nearly complete. In the first instance no signs of restored power were seen till seven months had elapsed, but in the other case return of power was noticed earlier, in fact, four months after the operation.

At Edinburgh University last week, the honorary degree of LL.D. was given, in his absence, to Dr. William Bayard. Sir Ludovic Grant said Dr. Bayard graduated at Edinburgh in 1837, and next month he would attain the age of 90. Dr. Bayard was in St. John's, New Brunswick, in vigorous health, actively prosecuting the duties of his profession He was the patriarch of the whole tribe of Edinburgh graduates throughout the world.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, July 28th, 1907.

Sued for Malpraxis.

An interesting case between doctor and patient has just been decided in favour of our confrere in the Paris Courts. A young lady was treated for appendicitis in the usual way; the icebag over the seat of the inflammation and opium by the mouth. Her attending physician omitted to place a layer of flannel between the ice and the skin and the consequence was congelation of the skin (the ice was kept on for twenty-five days!) with subsequent sloughing. She recovered from the appendicitis, but remained three months under treatment for the large superficial sore.

Two thousand pounds damages were claimed, but the Court gave judgment for the defendant. From the testimony voluntarily given by some of the highest medical authorities in favour of their confrere, the judges concluded that the doctor was not guilty of negligence, that the malady the patient suffered from was extremely dangerous and required heroic treatment.

All the same, were it not for the good backing he received, our friend would not have got off so well, In any case it is elementary prudence to place the ice-bag over one or two folds of flannel, and this he will not fail to do another time.

Moved with pity at the thought of suffering humanity constantly falling into the hands of those ogres, otherwise denominated medical men, a rich man in Paris wrote letters to the Charity Commissioners offering the sum of one million francs with a view of organising a system for controlling the acts and gests of the hospital staffs, imposing the condition that no medical man should be on the committee of this extraordinary organisation, which otherwise was to be composed of competent men of science!

The strange proposition on the part of a seeker of notoriety was treated with the merit it deserved, and the Charity Commissioners seized the opportunity for pronouncing their sympathy with the physicians and surgeons of the Paris hospitals and expressing their esteem and confidence in the staff whose devotion and scientific knowledge were never found at fault.

Early Diagnosis of Typhoid Fever.

Prof. Chantemesse, who discovered the serum of typhoid fever, made an interesting communication this week before the Académie de Médecine on a method for the early diagnosis of typhoid fever. He succeeded in producing a toxin which, when an infinitesimal dose is dropped into the eye, produces an inflammatory reaction of more or less intensity. Where the fever is not of a typhoid nature the reaction is very slight, lasting only two or three hours. The conjunctiva becomes red and the eye smarts a little. If the case is really one of typhoid fever the inflammation is almost intense, accompanied with more or less pain and epiphora. After two or three days, however, the eye returns to its normal condition without leaving any trace of the disturbance.

An Ostrich Stomach.

A few days ago, Jake, whose speciality consisted in swallowing everything that was brought to him, was brought to the Necker hospital with all the signs of perforation of the stomach.

Laparotomy was at once performed, and the following articles were removed: a boot hook, two steel chains, a handful of nails, needles and pins without number. The man succumbed.

Such cases are not rare among a certain class who exhibit themselves in low class music halls or on the fair green.

Some time ago a young girl who exercised the profession of swallower of pins, was presented to the Medical Society. For three years she went from café to café and before the public who likes this kind of spectacle, swallowed pins, broken glass and, above all, nails. Her health did not seem to suffer much and beyond a few colics attributable to a pin or nail badly placed, she enjoyed good health; the incongruous objects were expelled naturally.

In many cases these foreign bodies have remained weeks and months in the stomach without causing inconvenience.

It will be remembered that in 1866 a Japanese surgeon removed a tooth-brush from the stomach of a man which he had swallowed fourteen years previously.

Procreation of Sexes at Will.

M. Hurry, of Geneva, pretends that if conception takes place four or five days before the appearance of the menses, the child will be a girl. If it takes place five or six days after the menses, the child will be a boy.

An agriculturist presented his cows to the male two or three days after the rut to have a male and the first day of the rut to have a female. His intentions were realised twenty-nine times out of twenty-nine experiments.

Dr. Guiard reports thirty-five cases in which the law of Hurry was verified thirty-one times.

GERMANY.

Berlin, July 28th, 1907.

At the Medizinische Gesellschaft, Hr. Ewald showed a patient who had suffered from

Recurrent Hæmorrhages

from ulcer of the stomach, in which all the remedies tried, including escarine, had failed. In consequence of this, gastro-enterostomy was performed, with the result that no more bleedings took place.

Hr. Placzek communicated a note on

Circumscribed Adhesive Cerebral Arachnitis.

In the case of a young lady, æt. 25, the speaker had diagnosed a tumour in the right posterior cerebral fossa. The symptoms on which the diagnosis was based were the following: Vomiting, headache, giddiness, altered gait, inclination to fall to the right, almost complete paralysis of all the external ocular muscles of both sides, with implication of the frontal branches, and complete paralysis of the right side of the face. An operation performed by Krause showed a meningeal cyst of the under surface of the right cerebellar hemisphere, out of which an enormous quantity of liquor escaped. All the paralytic symptoms at once subsided, and the general condition became good. Then, on the tenth day after the operation, the temperature went up with sharp rises to 40° C. and more, then a rapid fall, followed by several days with a normal temperature. This condition lasted for several months and was occasionally accompanied by rigors and vomiting. In sharp contrast to this the general condition was excellent. As healing took place normally, and as every imaginable cause for the hyper-pyrexia could be excluded, there only remained the assumption that pressure on the medulla at the operation was the cause. The importance of the case lay in the clear determination of the fact that circumscribed collections of fluid in the soft cerebral membranes might set up symptoms similar to those of the tumour group.

Hr. F. Krause, who had performed the operation in the case, showed a series of projection pictures illustrating the method of procedure he now followed in cases of tumour of the posterior cerebral fossa. The skin and bone flap were naturally different, according to which side was being exposed. In that case there was supposed to be a tumour in the right posterior fossa. After opening up the dura it was seen that it did not project, and that it pulsated; it was thickened. It was opened, and, after being reflected back, the cerebellum was palpated. Nothing was found, and it was only near the medulla oblongata that a cyst was found, which contained about 150 cm. of clear fluid. After this had been emptied, cerebro-spinal fluid escaped, which up to then had not done so in any quantity. The cyst lay in the meshes of the arachnoid. That an adhesive process was present in the parts was shown by the fact that adhesions were present on the surface of the cerebellum that had to be dissected off.

The meshes of the arachnoid contained a good deal of fluid in the normal state, but under ordinary conditions it was diffuse; if adhesions were present anywhere, however, collections of fluid cysts formed The acute form of this condition had long been known to the aural surgeon. The existence of the condition in the chronic form could no longer be doubted. These cysts presented all the symptoms of cerebral tumours and had to be treated by operation.

Hr. Loewenthal related a case of amblyopia from poisoning by methyl-alcohol. A workman, æt. 29, three days after drinking a small quantity of methyl-alcohol, besides the general symptoms of poisoning, showed atrophy of the optic nerve in its early stage. Although the general symptoms had disappeared the sight had not returned, and the man was quite blind. The speaker concluded that methyl-acohol was a poison with strong elective affinities, which was very fatal, and the very few that survived remained blind. Its poisonous property was developed not only when taken internally, but also when applied externally, and when the vapour of it was inhaled. Individuality played the same part here as in other poisons. A dose of 8 cc. might be a very serious one for individuals with a predisposition to be affected by it.

AUSTRIA.

Vienna, July 28th, 1907.

Gall-Stone Colic.

Haberer presented a female, æt. 47, from Eiselberg's wards, who had suffered for fourteen years from gall-stone colic, which resulted in absolute closure of the ductus choledochus near its entrance into the duodenum, where the ulceration and finally the cicatrisation had so contracted the duct that absolute closure was the result.

Haberer had performed choledocho duodenostomy with an excellent result by maintaining temporary drainage of the lever for the bile during the period of healing. This was considered a crowning feat over the ravages of cholelithiasis.

Histological Changes in Stomach.

Bondi next gave the members a long description of the various changes that took place in the walls of the stomach in cases of diabetes when appearing as a morbid change and when induced by the administration of phloridzin. From microscopic preparations of the mucous membrane of the stomach in a case of pancreatic diabetes, as well as that from the stomach of a healthy dog, which had been treated with phloridzin, the glands contained drops of fat while the covering epithelium was quite free. Similar changes were present in the crypts of the small intestine as well as troma of the shaggy epithelial.

It was shown at a previous meeting that these changes took place in the liver in pancreatic and phloridzin diabetes, but not in the stomach and bowels, this is incorrect. In support of this condition Lombroso some time ago found by analysis that more fat came from the bowel of the pancreatic dog than from the healthy animal, this he could not account for at the time, but can now understand from the histological proofs. This fat is not obtained from the food taken into the alimentary canal, as dogs when hungered give the same result.

Erosions from Caustic Soda.

Preleitner has collected all the cases from the eight hospitals in Vienna that have been admitted within the last seven years, numbering 362 cases, mostly in children Of these 18.6 per cent. died in consequence of the erosion, 93.3 per cent. of the remainder suffered from cicatricial narrowing of the œsophagus, 10 per cent. having to be operated on in the form of gastrostomy to admit of alimentation and distension of the canal with bougies. Such a large number of children should be protected by some legal enactment modifying the sale of strong caustics and, if they must be sold compelling them to be delivered in a different form of bottle that might arouse caution.

Teleky quite agreed with Preleitner as he had drawn attention to this great sacrifice of life six years ago, but failed to arouse the government to action. It is scarcely possible to prohibit the sale of these powerful caustics, but they can be sold with more safety to the public than they are at the present time, by suitable bottles and attaching proper directons. It is scarcely possible to go as far as Preleitner would have us, as probably other more powerful substitutes might take their place in the domestic cleansing armamentaries.

Aggressin and Toxin.

Bail, of Prague, has been investigating the various fluids in disease, and assures us that there is always present the aggressive and toxic fluid as seen in diphtheria, where the antitoxic and anti-aggressive both exist. He affirms that all the semi-parasitic bacteria such as typhoid and dysentery have these two fluids in common which can be individually separated, though this is sometimes difficult. In the toxin itself there is a component part which is not poisonous of itself but is powerful in laming or weakening the cellular function which opens the path for the operation of the toxin. In the semi-parasitic group this aggressive immunity is equal to an antitoxin.

Lipomatosis.

Kirsch in a long article on this subject enumerates the various causes of super-nutrition, engorgement of vessels occurring in the anæmic as well as the healthy. He now adds the climacteric changes, juvenile degeneration, morbid changes in the genitals and metabolism. The most important of all are chronic alcoholism, syphilis, and the pastose or lymphatic form of scrofula. Balneo-therapeutics with chalybeate waters should be prescribed.

HUNGARY.

Budapest, July 28th, 1907.

At the recent meeting of the Budapest Interhospital Association, Dr. Boros read a paper on

Swelling of the Testis and Epididymis.

He classifies the enlargements of the testis and epididymis under the following heads:—(1) Acute (*a*) Gonorrhœa almost invariably involves the epididymis, seldom the body of the testis, or orchis proper. (*b*) Trauma almost always involves the body of the testis proper and but seldom the epididymis (*c*) Epidemic parotitis, or mumps, as a rule, affects only the orchis, or body of the testis proper. (*d*) Cystitis of non-gonorrhœal origin is a frequent secondary complication, as is also inflammatory enlargement of the epididymis. (2) Chronic: (*a*) Tuberculosis is the most frequent cause of chronic enlargement and, as a rule, first involves the epididymis, especially the tail of this portion of the organ, and later involves the body of the testis proper. It gives rise to a peculiar, nodular, very firm condition of the epididymis, feeling like a series of beads, and often extending in a similar manner up the vas deferens. (*b*) Syphilis in the majority of cases involves the body of the testis proper, and but rarely the epididymis. There are, however, exceptions to this, in which tertiary syphilis involves the epididymis, as well as the body of the testis. (*c*) Tumours or neoplasms of the testis may be either benign or malignant; the benign belong to the class of adenomas or chondromas, the malignant most frequently to the class of sarcomas.

Clean Milk Movement in Budapest.

The city health officer recently inaugurated a crusade for pure milk. The members of the city board, through personal visitation of dairies within and outside the city limits, acquired a first-hand knowledge of the situation that enabled them to effectively squelch the offending dairymen and their political backers in an attempt put forward to have the requirements and penalties laid down by the board set aside. From a number of analyses by the city bacteriologist, the board has decided that a dairy selling milk containing more than 500,000 colonies of bacteria to the cubic centimeter shall be the subject of investigation—surely, by the widest stretching of official amiability, no unreasonable standard. The situation is reviewed by a Budapest medical journal. There can be little doubt but that a large proportion of the vast number of digestive diseases among infants, with the many fatalities therefrom, can be traced to an impure milk supply. This being the case, it certainly becomes the duty of the municipality to safeguard the lives of the children of the citizens. The Board of Health and the health department officials deserve the hearty co-operation of all citizens in this much-needed work. Medical men, knowing the potent influence of an impure milk supply in inducing disease among infants, are especially obligated to lend the health authorities of Budapest their cordial co-operation and aid.

Dr. Roth read a paper on

Cancer of Intestinal Tract.

He said that cancer of the alimentary tract represents over 50 per cent. of all cancer. It used to be considered as most likely to develop in the middle life, and seldom under forty years. Now it is known to occur much earlier at times, and Dr. Roth saw a cancer of the rectum not long since in a new-born child. Often in these cases there is a little temperature and some tension of the rectus muscle, and while the surgeon is waiting for complete quiescence to do an interval operation, the cancer progresses too far for successful removal. Of the cancer of lower intestinal tract the most important sign is unsatisfied movements of the bowels. There is a sensation of unfinished business. Sometimes this symptom alone is sufficient to lead to investigation which discloses the cancer. Chronic constipation should not be treated for a considerable time, especially if it proves obstinate, without suspicion of cancer, and careful investigation along that line. In cancer of the intestines, where the new growth cannot be removed, the fatal current may be switched round the obstructions without the necessity for the inconvenience of an artificial anus. In inoperable cancer of the rectum, curettage followed by the cautery gives comfort and prolongs the patient's life.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

GLASGOW UNIVERSITY GRADUATION CEREMONIAL.

The annual summer graduation ceremony was held in the Bute Hall on July 23rd. The only honorary degree conferred was that of D.D. on the Rev. Ralph Wardlaw Thomson, Foreign Secretary of the London Missionary Society. After the ordinary degrees in medicine had been granted, the graduates were addressed by Professor Noel Paton, who dwelt on the effect of the study of medicine in stimulating a passion for the acquisition of knowledge for its own sake. The equipment gained during the five years of the curriculum was all too little to convert the raw recruit into a trained soldier, and he counselled the young graduates to delay their entry into practice until they had received further guidance and training. This might be got as resident in a hospital or by work in a laboratory, and he was glad to say that the two groups of workers, clinicians and laboratory researchers, were, year by year, coming more closely together. He spoke of the facilities for research now arising near home, making it unnecessary for students wishing to do research work to go abroad for that purpose, and in conclusion urged his hearers to be on their guard against following the easy path of quackery and humbug, and to follow the arduous path of straight dealing with themselves and their patients—the only path for honest men.

EDINBURGH UNIVERSITY GRADUATION CEREMONIAL.

This function took place in the MacEwan Hall on July 26th. The honorary degree of LL.D. was conferred on Wm. Bayard, M.D., St. John, New Brunswick, a graduate of the University of Edinburgh of sixty years' standing, who next month will attain the great age of 90, yet is still in vigorous health himself, and even engaged in ministering to the health of others. Dr. Bayard is the patriarch of Edinburgh Graduates, but not this, but the high esteem in which he is held by his Fellows, and the ennobling influence which he has exercised on the medical profession in New Brunswick, entitle him to the distinction his Alma Mater has conferred upon him. The graduates in medicine, law, and science having been capped and the various prizes and medals distributed, the address was delivered by Professor Sir Halliday Croom. He first spoke of the obligations which membership of the University brought with it, and of the inspiration which the traditions of their Alma Mater ought to give to the graduates. Not only this, but by enrolling themselves among the votaries of medicine they assumed responsibilities which only grew heavier as the years rolled on. Remembering that most of his hearers would become general practitioners, Sir Halliday Croom ventured on this parting advice: "First of all," he said, "however inconsistent this statement may seem to you, you must never have a practice. You must never think to have under any circumstances any vested right in your patients. Your patients constitute a practice just so long as you attend them, and no longer. They have a perfect right to demand the best of your skill and energy, and they have equally good right to demand the same from someone else the next time they require attendance. When you bid your patient 'Good-bye,' after attending him, it ought to be 'Good-bye,' and not necessarily 'Au revoir.' You must be independent of your patient, and your patient must be independent of you. The old-fashioned relationship of the family doctor, like that of the regimental surgeon, who regarded his clientele as his strict preserve, has in our day been much modified, and in this age of strenuous competition it is well that it is so." Speaking next of medical ethics, he asked: "What, in fact, are medical ethics? What are the ethics that regulate the conduct of one gentleman to another? Nothing, absolutely nothing, but the words to which we have been accustomed since childhood: "And, as ye would that men should do unto you, do ye also to them likewise." No rules or regulations, no code of ethics, no manual of etiquette, would ever be a better guide than abiding by the old formula. Sir Halliday Croom then urged that the art as well as the science of medicine should be cultivated. The problems yet unsolved were many. In anatomy there was still much to be done, especially in regard to the nervous system. In obstetrics, putting aside all other questions, the great subject of eclampsia, in its pathology and treatment, still remains unsolved, while gynæcology offers ample opportunity for original work. It remained also for some of them to complete in surgery the work of Lister and Pasteur.

After the ceremony, a House Luncheon was held in the Union. Last year, it may be remembered, Sir Donald Currie and Mr. Carnegie each promised £6,000 conditionally on the Union raising a similar sum. The total £18,000 being the sum required to pay off the debt on the extension. The Union succeeded in doing its part, but the estimates for the extensions were exceeded by £1,200, leaving the institution still indebted to that amount. About half the requisite amount of this second sum has also been raised, and at the luncheon Sir Donald Currie intimated his willingness to clear off the balance. The University union has indeed been fortunate in its benefactors; we doubt whether anywhere a more luxurious and well-managed club exists with so low a subscription.

ABERDEEN UNIVERSITY GRADUATION CEREMONIAL.

The Summer Graduation in Arts, Science, and Medicine was held in the Mitchell Hall on July 25th. After the degrees had been conferred, Principal Laing reviewed the present position of the university. In the quinquennium that had now nearly terminated, they had received from the Carnegie Trustees for equipment, teaching, and research, the sum of £45,000. With balance remaining, and the assurance that equally liberal treatment might be expected in future, there is reasonable prospect of further additions to the professional staff, and further contributions to the efficiency and sufficiency of university instruction.

LETTERS TO THE EDITOR.

THE GENERAL PRACTITIONER.

To the Editor of The Medical Press and Circular.

Sir, I have read with pleasure the articles that have appeared in the Medical Press entitled The General Practitioner. I quite agree with Dr. Tayler that it is very difficult for a medical man in a busy and exacting practice to find time for reading, and many of us have to do most of it in our broughams whilst visiting our patients, and undoubtedly there has been in the past a deficiency of books written specially for the general practitioner.

The young practitioner just entering into practice finds difficulties which have not been encountered by him during his hospital curriculum.

1st.—He is puzzled and does himself no credit when patients come to him complaining of minor ailments. He cannot do better than read carefully Dr. Leonard Williams's readable book on "Minor Maladies."

2nd.—During his hospital career he has seen the major operations of surgery performed by brilliant operators, nearly all of which he will never be called upon to perform in practice, but the management of these cases after the operation in the patient's house or in a private home he will be expected to look after. He will find Lockhart Mummery's "The After-Treatment of Operations" of great help to him.

3rd.—The general practitioner finds it difficult to decide what operations it would be safe and advisable for him to undertake. The recently published work, "Operations in General Practice," by Corner and Pinches, he will find a God-send. As these authors say: "At the beginning of his career the practitioner is prepared to do much surgery, but experience teaches him what he may safely undertake, and from what he should abstain, he has learnt that it is not so much the question of operation as the question of policy which must determine his professional action, a practitioner may refuse to do a so-called minor operation and the next day perform a major one."

If I had read this book twenty years ago I should have attempted to do many operations that I have not done, and left undone many operations that I have attempted to do. Having in a town practice the best operating surgeons within easy call, the trouble and anxiety of many of these operations is not in proportion to the comparative small fee that a general practitioner can charge.

In conclusion I wish to protest against the laboratory refinements that a student is expected to learn in these days. When in practice it will pay him better to subscribe annually to a pathological laboratory and have the sputum and diphtheritic membrane examined, the "Widal reaction" test, the "Diazo reaction" of urine, etc. done for him by pathological experts, and devote his time to more remunerative work.

I am, Sir, yours truly,
James Edwards,
Surgeon to the Liverpool Police Force, etc.

To the Editor of The Medical Press and Circular.

Sir,—The majority of the profession being general practitioners, your readers are no doubt mainly composed of the same class, and these all must feel under an obligation to Mr. J. Lionel Tayler for the series of suggestive papers he has contributed to your valuable journal. Successful general practitioners, the minority who are doing large practices among the wealthier classes, have no time to think of the difficulties of the mass of their brethren, whilst specialists and consultants have even less knowledge of and probably less sympathy with their case. If the general practitioner is to be helped into a better moral and material position it must be done by his own hand. Until an organised combination can be formed progress in any direction will remain impossible. An association of twenty thousand men speaking with one voice might easily make itself heard and felt. Of course the British Medical Association is already in existence, but I would ask what has it ever done to advance in any way the interests of the mass of the profession? It is almost entirely a co-operative society for the publication of a medical journal—a journal which rarely discusses or advocates reforms upon which the vital interests of the general practitioner depend. If these men will not set to work with determination to help themselves they may as well bear their grievances in silence—no help from outside will ever come to them.

I am, Sir, yours truly,
London, W. G. P.
July 25th, 1907.

DEBTORS AND CREDITORS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Can you comment on Judge Mulligan as reported in the *Cambridgeshire Times?* He has only recently been appointed in place of Judge Willis, K.C., and the latter judge and his predecessor, Judge Price, K.C., for a period extending over the last twenty years allowed debt collectors to appear and prove debts thus saving a lot of time and trouble to creditors and a lot of expense to poor debtors. Judge Mulligan, like the proverbial new broom, not only sweeps all this practice away but pretty plainly singles out four medical men insinuating that their conduct has been "nefarious." The practice for twenty years having been for the debt collector to get in his debt by small payments as convenient to the debtor as possible; when the debtor ceases to pay, the collector then gets written acknowledgement of his debt and the court always gave judgment for the acknowledged debt, the collector getting in his debt by instalments and charging 2s. in the £ to the creditor for his trouble—the debtor being put to no other expense than the court fees.

The way proposed by Judge Mulligan is the same as was in vogue some twenty-five or thirty years ago, before debt collectors were known, which was to give your list of debts to a solicitor who applied to such debtor by letter for which a fee was charged, then another fee for appearance in court, both fees being added against the debtor, and after judgment was obtained in court the debt was never followed up and, in fact, the county court for collection of small debts was a mockery, a delusion and a snare. Judge Mulligan by his inconsiderate action is making his court useless to small creditors, expensive to small debtors and an exception to every other court in the kingdom.

I am, Sir, yours truly,
MEDICUS.

SPECIAL ARTICLE.

ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION.

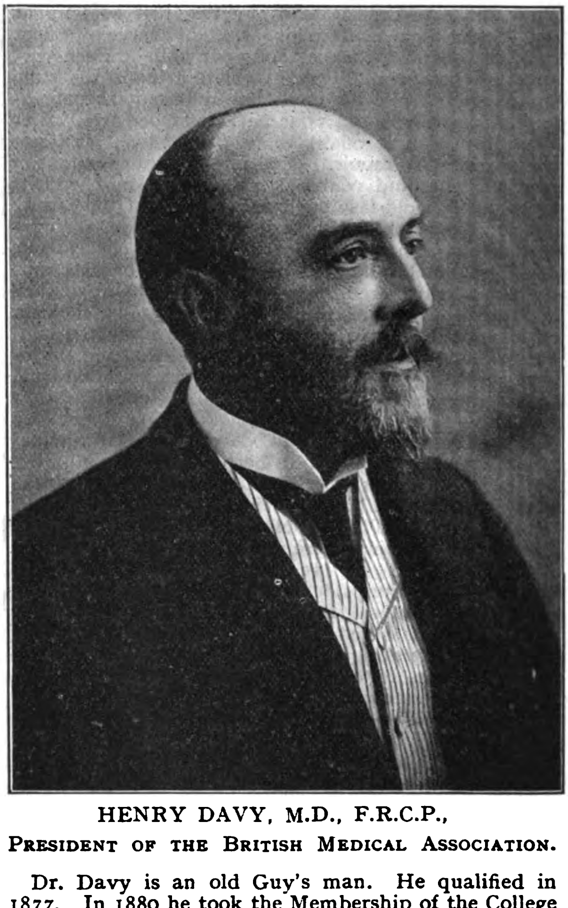
Exeter, July 27th to August 3rd, 1907.

[*From our Special Correspondent.*]

EXETER, the capital of England's West Country, is a peculiarly fit, proper and delightful meeting place for the annual picnic and yearly conference of so representative a body as the British Medical Association. This year's gathering already promises to be one of the most interesting and attractive of recent years. The meeting has opened under auspicious circumstances. Evidences of open-handed hospitality are apparent everywhere. Elaborate preparations have been made for the coming of the visitors. A promising programme has been arranged for those intent on the acquirement and dissemination of knowledge. The pleasure-seeking medicos from crowded cities and restless towns will find in this ancient cathedral centre a soothing and restful atmosphere; and in its surrounding country a veritable paradise of varied charms, which will provide restorative powers for the body as well as endless delights for the mind.

THE NEW PRESIDENT.

All will be wishful to tender hearty congratulations to the incoming President. Dr. Henry Davy has long been a prominent and honoured leader of Medicine in the West. His courtesy and consideration, knowledge and tact have won him wide popularity among both practitioners and patients. He has always maintained a high ethical standard and sought to further the interests of his profession and secure the benefits of science for the welfare of his fellow countrymen. His modesty and dislike for anything savouring of advertisement is well known by all his friends, but they will thank us for having secured, and here presenting, a photograph of the head of the B.M.A.



HENRY DAVY, M.D., F.R.C.P.,
PRESIDENT OF THE BRITISH MEDICAL ASSOCIATION.

Dr. Davy is an old Guy's man. He qualified in 1877. In 1880 he took the Membership of the College of Physicians of London, and was elected a Fellow in 1894. At his M.B. of London, in 1878, he took honours in Medicine, Obstetrics and Forensic Medicine, and, in 1882, proceeded to the M.D.

Dr. Davy has enjoyed much hospital experience, having served as House Physician and Resident Obstetric Assistant at his own school of Guy's Hospital, as House Surgeon at the Evelina Hospital for Children, and as Resident Clinical Assistant to St. Luke's Hospital for the Insane.

Settling in practice in Exeter he quickly made for himself a name and a place, and as Physician to the

Devon and Exeter Hospital and the Exeter Dispensary he exercised a wide influence on the local medical life of his city and its neighbourhood.

As evidence of his popularity in the profession it will be sufficient to note that when, in 1897, he was elected President of the South-Western Branch, every medical practitioner in Exeter contributed to present him with a peculiarly fitting token of esteem: his badge as a Sheriff of the City.

Dr. Davy has not only proved himself a popular and successful physician but has shown himself a valued contributor to Medical Science, having written on the pathological features of pernicious anæmia, movable kidney, pyrexial states in children and Addison's disease. His presidential address, an abstract of which we print elsewhere, in this number, affords abundant evidence that he views matters medical through a wide-angled lens and fully realises the important place that the physician and surgeon must take in the public life of the nation and the urgent need for an extension of scientific methods to all pertaining to the development of the best life of our country.

An Artistic Handbook.

Through the courtesy of the President we have been favoured with a copy of "A Book of the South-West," a handsome and charmingly illustrated work specially prepared for the delight and edification of medical visitors to our Western land. It will prove a revelation to many of the glories of the Delectable Duchy and the beauties of the Shire of the Sea Kings, and will long be treasured and, if we mistake not, be frequently used as an authoritative volume of reference. Mr. A. Wallis contributes a graceful and informing sketch of Devon and Cornwall, and Mr. A. T. Quiller Couch reveals something of "The Secrets of Cornwall." There is much valuable information on the physical and climatic features of the two counties and reliable directions regarding points of local interest and matters which may guide in the choice of a suitable health station for particular classes of patients. But the most striking and fascinating features of this most artistic volume are the many varied and admirably executed photographic reproductions. Everyone concerned in the production of this attractive and permanently useful momento of the Exeter meeting deserve warm congratulations and sincerest thanks. This volume will, for many a long day to come, serve to keep in remembrance the winning beauties of the West and very pleasant recollections of a thoroughly enjoyable annual meeting.

A Week's Programme.

Business, science and pleasure are amply provided for. The official representatives of the Association gathered on Saturday, the 27th, and continued their meetings on Monday and Tuesday, the 29th and 30th. On Monday the Mayor of Exeter held a reception in the Guildhall. Yesterday (Tuesday, July 30th) a service was held in the Cathedral at noon; in the afternoon a garden party was given by the Mayor; and at night the President delivered his official address. The Pathological Museum offers many objects of much interest. The Annual Exhibition of Foods, Drugs and Appliances promises to be well patronised. The work of the thirteen sections will doubtless prove to be of service, although there is no likelihood of the presentation of any startling novelties. Several discussions are likely to arouse heated argument. In so delightful a centre excursions, tours, and entertainments not unnaturally occupy a foremost place in the arrangements of the majority of the visitors. The list provided is most attractive. Only a real, old-fashioned Devonshire summer weather is wanted to crown the seventy-fifth annual meeting of the B.M.A. with complete success.

Dr. Vacher, the medical officer of Cheshire, in his annual report for 1906 says Stalybridge has the highest infant mortality rate in the county—206 per thousand.

OBITUARY.

SURGEON-COLONEL EDMUND G. McDOWELL, C.B., L.R.C.S.

We regret to announce that Surgeon-Colonel Edmund Greswold McDowell, C.B., died at Portland on July 26th last, at the residence of his son-in-law, Major E. W. Briscoe. The deceased officer was born on November 30th, 1831, and, after qualifying L.R.C.S.I. in 1855, entered the Army Medical Service as an assistant surgeon in the 44th Regiment. He was promoted surgeon on September 3rd, 1870, surgeon-major on March 1st, 1873, brigade surgeon in the Army Medical Department on August 4th, 1881, and deputy surgeon-general on March 4, 1886, retiring as a surgeon-colonel of the Medical Staff on November 30th, 1891. He served with the 44th Regiment in the campaign of 1860 in North China, including the action of Sin-ho and the storm and capture of the Taku forts (medal and clasp), and in the Egyptian war of 1882 (medal, 3rd Class of the Medjidieh, and Khedive's star). He also served in the Sudan expedition under Sir Gerald Graham in 1884 as principal medical officer, and was present in the engagements of El Teb and Tamai (twice mentioned in despatches, C.B., and two clasps). Besides one daughter he leaves two sons, Major F. McDowell, R.A.M.C., and Dr. D. K. McDowell, C.M.G., Principal Civil Medical Officer, Straits Settlement.

SURGEON-GENERAL ALEXANDER FRANCIS PRESTON, B.A., M.B.Dub.

We regret to announce that Surgeon-General Alexander Francis Preston, M.B., honorary physician to the King, late of the Army Medical Service, died last week at his residence in South Kensington, at the age of sixty-five Graduating at Trinity College, Dublin, in 1863, he joined the medical service of the Army the same year, and served in medical charge of the 66th Regiment in the Afghan War of 1880, when he was present at the affair at Ghirisk, the battle of Maiwand, where he was severely wounded, and throughout the siege of Kandahar, obtaining mention in despatches. He was promoted surgeon-major, with the relative rank of lieut.-colonel, and awarded the medal. In 1896 he reached the rank of surgeon-general, was temporary director-general of the Army Medical Department in 1901, and the following year was placed on the retired list. Surgeon-General Preston had been a honorary physician to the King since 1901.

REVIEWS OF BOOKS.

RECENT WORKS ON TUMOURS (*a*).

Mr. Sampson Handley's work on the dissemination of cancer is already well known to surgeons and pathologists by his Hunterian lectures, his Astley Cooper Prize Essay, and his contributions to the "Archives of the Middlesex Hospital." In the present volume (*a*) he has systematised his observations and conclusions in so far as they bear on the subject of Cancer of the Breast. The result is the most important work in surgery or pathology which has appeared in England for many years.

Mr. Handley starts with a criticism of the fashionable theory of the dissemination of cancer—the embolus theory. He shows, by citation of cases, how unsatisfactory the theory is. "Blood embolism must by its very nature, be an indiscriminate process; the cancerous emboli must be distributed impartially to all the organs. Why then in certain cases do the cancerous emboli gain a footing only in the abdominal organs, and in other cases only in the thoracic organs? The hypothesis of tissue predisposition does not meet the difficulty." . . . "Quite clearly it (the embolic theory) is not, standing alone, an adequate and complete explanation of all the remote metastases of cancer." . . . "Blood embolism, far from being a dominant and universal factor in the dissemination

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(*a*) "Cancer of the Breast and its Operative Treatment." By W. Sampson Handley. London: John Murray. 1906. Pp. xii and 237. Price 12s. 6d. net.

of breast cancer, appears to be an event of exceptional occurrence, and one which, even when it occurs, is usually rendered ineffective by the destruction of those cancer cells which gain access to the blood stream." (Pp. 14, 15).

Having scotched the dominant theory, Mr. Handley proceeds to develop his own. He first describes the topographical distribution of the secondary growths in cases of cancer of the breast, and he next shows the paths by which the disease spreads. The main point of his teaching can be put in a short sentence—Cancer spreads by direct growth along the lymphatic channels. Moreover, this "permeation takes place almost as readily against the lymph-stream as with it." This growth Mr. Handley is able to demonstrate with the microscope. At some distance from the primary tumour "the principal lymphatic pexus of the part, the pexus which lies upon the deep fascia, is found permeated throughout, that is to say, its vessels are obstructed by the growth of lines of cancer cells along them" (p. 93). Somewhat nearer the primary tumour these permeated lymphatics are not found, a fact which seems to present some difficulty. It is shown, however, that the permeated lymphatics have been destroyed by a process of perilymphatic fibrosis. These various statements, though made boldly, are by no means unsupported. Mr. Handley marshals his evidence clearly and firmly, and it is all but impossible to impugn any of his views, however revolutionary they may appear.

Having acquired a knowledge of the mode of spread of cancer, Mr. Handley proceeds to study the particular case of the relation of visceral dissemination to cancer of the breast. He shows by purely anatomical considerations how readily the epigastric angle and, subsequently, the liver become affected.

Finally, he comes to the practical question of the application of his views to operations on the breast. As the disease spreads not at the level of the skin, but at the level of the lymphatic plexus on the deep fascia, it is obvious that in the removal of the part the deep fascia must receive special attention. The glands, however, are to be seen to as carefully as heretofore, since, when the permeation process reaches a gland, emboli may be formed which carry on the disease to more distant glands. In Mr. Handley's words, therefore, "the object of the operation should be the removal of the permeated area of the lymph-vascular system which surrounds the primary growth, and of the lymphatic glands which may have been embolically invaded along the trunk lymphatics of the area concerned" (p. 178). He details not merely the principles governing the operation, but gives all the steps clearly enough to guide the surgeon.

In an appendix, the author discusses lymphatic permeation in the spread of melanotic sarcoma.

Mr. Handley's work comes from the Middlesex Hospital Cancer Research Laboratories, and would be, even if it stood alone, sufficient justification for their existence. No one, however crusted he may be in tradition, can read the volume without seeing that, whether accepted in every detail or not, Mr. Handley's researches and conclusions cannot be overlooked. Most readers will come away convinced that a great step forward has been made in our knowledge of an important branch of pathology. What Mr. Handley has done for cancer of the breast must be done by himself or by others for cancer of other regions, and we are glad to learn that he is at present investigating the problem as it concerns the stomach.

In the presence of so much important material, it is hardly worth mentioning that the style of the author is excellent, and that his argument is both clear and concise. The general form of the book, as is usual with Mr. Murray's house, is all that can be wished.

Mr. Charles Cathcart's book (*b*) comes as a useful protest against the current fashion of treating of the "cancer problem" as a thing apart from the general problem of tumour formation. Such isolation of part of a question can only lead to confusion and wasted labour, and although the distinction between "innocent" and "malignant" is of great importance both clinically and pathologically, yet it is never absolute, and there is a wide debatable land between the two territories. Mr. Cathcart arranges his arguments in three battalions which reinforce each other in attack. First, he shows by description of several series of tumours, the easy gradation from the obviously innocent to the obviously malignant. Next, he details instances of the transformation of innocent into malignant growths. Finally, he gives examples of tumours presenting various combinations of innocency and malignancy. Mr. Cathcart's series are illustrated by excellent photographs of gross specimens, but he does not supply the series of microscopic sections which would prove equally instructive. There is nothing particularly novel in the ideas presented, but the book will be of service in emphasising the essential unity of the tumour problem.

Mr. Bland-Sutton's book on Tumours is so well known to the profession that the appearance of a new edition (*c*) hardly calls for prolonged notice. The special features of Mr. Bland-Sutton's book have always been its comprehensiveness and its elucidation of the subject by the aid of comparative pathology; while it had the added interest that it vigorously expressed the views of a teacher of marked originality and wide experience. These features it possesses still, the last mentioned perhaps to an extent hardly satisfying to the demands of the logic of science. Dogmatic statements abound where tentative opinions would have been more fitting. For example, the discussion of carcinoma of the ovary (p. 515) opens with the statement, "Primary cancer of the ovary is a rare disease, and one concerning which we know little." In the bibliography at the end of the chapter only one reference is given to any work on cancer of the ovary more recent than 1902; if Mr. Bland-Sutton had consulted more recent literature he would have found that in the practice of other surgeons the disease is by no means rare. The present reviewer has had submitted to him for pathological examination no less than three cases within a fortnight. On p. 61, we meet the extraordinary statement that "Myomata, or tumours composed of unstriped muscle fibre, are very rare," although the author immediately quotes the uterus as one of the sites for them. We have been unable to detect the difference between the myeloma or myeloid sarcoma, described in chapter iv., and the sarcoma of bones, in chapter vii; both microscopically and macroscopically they appear from the description to be indistinguishable. It is an ungrateful task finding fault with an old friend such as this book, but it is just because the book is regarded as an authority that we are constrained to point out that the pathological sections have not been sufficiently revised or brought up to our modern knowledge. In regard to treatment, Mr. Bland Sutton is a more trustworthy guide.

Those who are interested in Poor-law reform will be interested to learn that a fund is being collected to present a suitable testimonial to Dr. Milson Rhodes. The movement was started at Didsbury, Dr. Rhodes' own district, and close to the Chorlton Union, with which his name is so closely associated. It will be remembered that he was one of the founders of the Association of Poor-law Union. A considerable sum of money has been already subscribed, and the Editor of the *Poor-law Officers' Journal*, Whitefriars Street, London, E.C., will be pleased to receive any further contributions to the fund.

(*b*) "The Essential Similarity of Innocent and Malignant Tumours: A Study of Tumour Growth." By Charles W. Cathcart, M.A., M.B., C.M. Edin.)., F.R.C.S. (Eng. and Edin.). Illustrated. Bristol: John Wright and Co. Pp. xii and 79. Price 9s. 6d. net.

(*c*) "Tumours, Innocent and Malignant, their Clinical Characters and Appropriate Treatment." By J. Bland-Sutton, F.R.C.S. Fourth edition. With 355 engravings. London: Cassell and Co. 1906. Pp. xii and 675. Price 21s.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Relation of Ovarian Cysts to Abdominal and Pelvic Pain.—Sampson (*Surg. Gynæcol. and Obstetrics*, June, 1907).—The sensibility of the walls of eight large ovarian cysts was studied and all were found to be insensitive to touch and pain. Traction on the pedicles caused pain which became greater as the traction was increased. The pain was usually at first localised in the side of the abdomen at or about the pelvic brim but as the traction was increased it became more diffuse. When diffuse it was felt over the entire side of the abdomen or in the back, and as soon as the pedicles were released the patients were immediately relieved. His observations on the sensibility of the normal tube, ovary, and uterus do not entirely accord with those of Linnander, who thinks that they are insensitive, for while finding them so in some cases when pinched with a mouse tooth forceps. Yet in a number pinching these structures caused pain. Again intraperitoneal pelvic operations have been found by the writer to be less painful in women past the menopause, and the instances of apparently sensitive ovaries, tubes, and uteri have occurred in younger women, but even here the apparent sensibility to pain has been inconstant, and when present it has always been much less than that of the parietal peritoneum, and the ovary has seemed the least sensitive of the three. In all cases the parietal peritoneum was found to be *very sensitive*, and especially to traction The omentum and intestines were found to be insensitive to pinching. He sums up as follows: The presence of abdominal or pelvic pain in patients with ovarian cysts usually indicates either secondary changes in the cyst involving some sensitive near-by structure or the presence of some other condition, independent of the cyst, which may cause pain. The principal causes of pain from ovarian cysts are traction or twisting of the pedicles or the traction of the parietal peritoneum from adhesion. F.

Ectopic Gestation with special reference to the Treatment of Tubal Rupture.—Robb (*Amer. Jour. Obst. and Gynæcol*).—The writer quotes the opinions of recognised authorities and then concludes his paper with the following account of the method adopted by him for tubal rupture during the past four years. If there are signs of improvement in the patient's condition (and this in his experience always takes place) he keeps the patient under further observation. The change for the better is brought about by carefully stimulating the patient by means of saline infusions under the breasts, and in some instances also by means of hot saline enemata. If the patient is not vomiting or not nauseated, a stimulant in small quantities is administered by the mouth. In addition morphia is given hypodermically for the pain and nervousness. External heat is applied to the body and the lower end of the bed is slightly elevated. Sulphate of strychnine is also given hypodermically in doses of 1-10 to 1-20 of a grain every half hour or so, according to the indications. While this treatment is being carried out, the operating room is prepared, so that it can be used at a moment's notice. This treatment is also carried out at the patient's homes. Then as soon as the woman had recovered from the shock of the rupture she was transported to the hospital, where an operation could be carried out at any time that the necessity might arise. Every patient in the series of twenty had gradually improved, so that after two or three days, and in some instances after twelve day's time, the operative procedures have been carried out with very little, if any, shock to the patient. The writer is not prepared to state dogmatically that women do not bleed to death from hæmorrhage following ruptured tubal pregnancies, but he is of the firm conviction that surgeons are losing many of their desperate cases from over-haste in operating upon them. F.

Valvular Disease of the Heart in Pregnancy and Labour.—Newell (*Sur. Gynæcol. and Obst.*, May, 1907). Any organic heart lesion, even if perfectly compensated under normal conditions of life, should arouse apprehension and call for constant watchfulness if pregnancy supervenes. In case pregnancy comes as a complication when the heart lesion is imperfectly compensated, the indication is for immediate relief by emptying the uterus, since a heart which is not able to care for its ordinary work has no chance of supporting the added burden of pregnancy. When a previously well compensated heart fails under the extra work thrown on it by pregnancy an attempt may be made to restore compensation by test and appropriate treatment, but unless the measures are promptly successful the heart must be relieved by the removal of the extra burden. In any case in which an organic heart lesion can be demonstrated, even though it may have caused no symptoms during pregnancy, labour should be regarded with apprehension, and every means should be taken to shorten the strain of labour and thus relieve the heart of its extra burden, although it may seem to be doing its work satisfactorily. F.

Hyperemesis gravidarum and its relation to eclampsia.—Skorbanski (*Zentralbl. fur Gyn*, Nr. 27 1907). Four hypotheses exist concerning the ætiology of Hyperemesis gravidarum: (1) The hypothesis of the simple reflex from the uterus to the stomach; (2) The auto-intoxication hypothesis which declares that the hyperemesis is the result of intoxication of the body by toxines which arise in the intestine, in the stomach, in the liver, or in other organs; (3) That it is hysterical in origin; (4) That the intoxication of the organism arises from poisons which develop in the ovum. In the author's opinion the last hypothesis best explains the different cases of hyperemesis; it also explains the relationship between hyperemesis and eclampsia. Hyperemesis in the first half of pregnancy can arise as a result of the immunisation of the organism by an antitoxin produced from products of the disappearing villi. This antitoxin is necessary for the organism at the end of pregnancy, when large masses of toxines arise. When immunisation at the beginning of pregnancy is successful, the organism easily overcomes these poisons at the end of pregnancy, but when it is unsuccessful eclampsia is observed. Thus eclampsia most frequently assails healthy women who felt perfectly well during their pregnancy. Some cases of eclampsia which came under the author's observation in Prof. Rein's klinik in St. Petersburg strengthen the author's belief in this hypothesis, the first half of pregnancy gave them no trouble. There are, however, eclamptic patients who suffered during the first half of their pregnancies from severe hyperemesis; one must conclude that in these cases in spite of the poisoning of the organism during the first half of pregnancy a sufficient amount of immunisation material was not produced. In conclusion the author describes a case of hyperemesis for which abortion had to be induced. G.

The Corpus Luteum.—Fellner (*Med. Klinik*, 1906, Nr. 42) reviews all the latest investigations and opinions concerning the corpus luteum and its internal secretion. The difference has long since disappeared, which was formerly made between the corpus luteum of menstruation and that of pregnancy. While Sobotta considers that the lutein cells arise from the granulosa cells a not inconsiderable number of authors adhere to the investigation of Stoeckel, who sought to prove their origin from the theca cells. Numerous investigations have been made concerning the cystic changes in the corpus luteum, which by the presence of blood one can generally distinguish from cysts of the Graafian follicles. Hæmorrhages into the interior of the cysts can be very dangerous, even fatal. According to Stoeckel multiple cysts depend on an abnormally fast rate of ripening of the follicles and corpus luteum formation, which passes off without opening of the follicle and thus leads to cyst formation. The investigations concerning the simultaneous appearance of ovarian changes on the one hand and hydatidiform mole and syncytioma on the other have excited especial interest. All the properties which were formerly entirely attributed to the ovary are attributed now by Fraenkel, on the ground of numerous experiments, to the corpus luteum alone. Although we do not yet know anything certain concerning the function of the corpus luteum, we must conclude that the corpus luteum is a gland with an internal secretion. G.

Prolonged Pregnancy.—Bossi (*Zentralbl. fur Gyn.*, No. 27, 1907) regards pregnancy as prolonged when it exceeds the term of 285 days, without any symptoms of labour. Such a condition exists among 2—3 per cent. of all pregnant women, and may cause severe complications during delivery. The characteristics of the ovum are as follows: (1) Unusual length of the fœtus; (2) the bones of the head are larger and more ossified; (3) a well marked disproportion between the length, ossification, and the size of the head bones and the weight, which is usually less than is expected. The author fully describes some cases out of the fifty-two observed by him in order to illustrate the difficulties which often arise. The frequency of uterine inertia is remarkable. Bossi is inclined to refer this to the fatty degeneration which the muscle fibres undergo when gestation exceeds its normal length. The treatment indicated is artificial induction of labour, and pubiotomy when the head is so ossified and hard that even with Walcher's position safe delivery is uncertain. G.

Hæmorrhages at the Beginning of Puberty.—Fischer (*Monatssch. für Geb. und Gyn.*, Bd. XXV., Hft. 4) records the case of a girl, æt. 12, who for two years had suffered from practically continuous hæmorrhage from her gums. She was extremely anæmic. She bled very severely during her first menstruation. Examination revealed a normal condition of the genitals. Ergot, adrenalin, vaginal plugging, and even plugging of the uterus with perchloride of iron wadding and tannin gauze were of no avail. Finally she was curetted, and this was successful. The endometrium removed proved to be normal, but rather poor in glands. A second case, a girl, æt. 14, had bled uninterruptedly for six weeks. She was very anæmic, the quantity of hæmoglobin in the blood being 10 per cent. On the trunk and on the extremities there were little points of hæmorrhage. Curettage stopped the bleeding, but did not give sufficient material for microscopical examination. Eight days afterwards she died from profuse nasal epistaxis. The first case was one of hæmophilia, the second of purpura hæmorrhagica. There have been several cases of hæmophilia in women recorded lately. As regards the second case, uterine hæmorrhages have been observed complicating purpura hæmorrhagica. In conclusion, the author discusses a series of eleven cases in which severe hæmorrhage was associated with the first menstruation. G.

High Forceps.—Riemann (*Monatssch. für Geb. und Gyn.*, Bd. XXV., Hft. 4) reports the results obtained with high forceps in the Breslau school for midwives. In his opinion they are not so dangerous for the mother and child that they should be rejected generally, especially in cases of contracted pelvis. The fœtal mortality was 22 per cent.; maternal injuries, 7 per cent.; fœtal injuries, 10 per cent.; and the puerperium was prolonged in 16 per cent. of the cases. All this proves that high forceps should not be employed without the strongest indications—*i.e.*, danger for either the mother or child. The best results are obtained when the head is well moulded and the child in good condition; that is when the forceps are indicated for the mother's sake. In such cases it is possible to deliver relatively large uninjured infants, when the conj. diam. measures from 8-8¾. The usefulness of the high forceps diminishes as the contraction of the pelvis increases. G.

Ovariotomy during Pregnancy, Labour, and the Puerperium.—Retzlaff (*Monatssch. für Geb. und Gyn.*, Bd. XXV., Hft. 4).—In the first case a IV.-para., æt. 35. During bimanual examination a tense and elastic tumour was found in Douglas's pouch, which laparotomy showed to be a parovarian cyst the size of an apple, with its pedicle twisted, lying behind the pregnant uterus. In a second case the uterus was enlarged to the size of three months' pregnancy and retroflexed; on top of it was a cystic tumour the size of a child's head. The laparotomy revealed a dermoid of the right ovary. Operation did not interrupt the pregnancy in either case. In a third case the uterus, slightly enlarged, was pressed against the symphysis by a tumour in Douglas. A dermoid cyst was removed by colpo-cœliotomy. The pregnancy went to full term. The author now discusses the combination of pregnancy and ovarian tumour, and says that it is difficult to declare which is the best procedure to adopt regarding operation. One must consider the period of the pregnancy, the size and nature of the tumour, its position, and the condition of the other ovary. It is more unfavourable when the tumour does not reveal itself during pregnancy, but is first discovered at the beginning of labour, when it may prolong the expulsion of the ovum or perhaps render it impossible. As examples the author describes two cases. If the ovarian tumour is diagnosed intra partum, and it is an obstruction to labour, an effort may be made to replace it either from the vagina or rectum with an anæsthetic if necessary, so that the labour may proceed as naturally as possible. If it is impossible to replace it, an ovariotomy must be performed. The puerperium can also be complicated in a most unpleasant manner by ovarian tumours. It seems as if the long-continued compression and crushing produced by difficult deliveries so very much lowers the vitality of the tumour tissues that they afford an especially favourable breeding-ground for the development of infection spreading upwards from the genital tract. G.

Appendicitis and Pregnancy.—Puech (*Provence Med.*, 1906, Nr. 52) reports two cases. In the first, appendicitis developed at the seventh month of pregnancy, and was not recognised at the beginning. Three days later the diagnosis was made, and, owing to the severity of the case, an operation decided on. It was not performed, however, as the patient began to improve. Less than 24 hours after this decision the patient died. In a second case a patient six months pregnant was suddenly seized with very severe pains, vomiting, etc. A diagnosis was first made of kidney colic. The author, when summoned, made the correct diagnosis, and as the patient's condition did not improve, he operated. A day and a half later she delivered herself spontaneously of a dead six months' fœtus. The convalescence was uneventful. As a result of these observations the author warmly recommends operation in such cases. G.

Arrangements for the amalgamation of the London Royal National and City Orthopædic Hospitals have now been completed. Dr. Hughlings Jackson has been elected Honorary Consulting Physician to the Royal National Orthopædic Hospital, and Dr. Sutherland, Mr. John Poland, and Mr. J. Jackson Clarke have been elected Honorary Physician and Honorary Surgeons respectively. The new building operations have been begun, and a hospital for 213 in-patients is being built on the site of the old hospital and the adjoining premises.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.

An ordinary meeting of the council of the Royal College of Surgeons was held on Thursday last, Mr. Henry Morris, president, in the chair. Mr. Louis A. Dunn, F.R.C.S., Surgeon and Lecturer at Guy's Hospital, was elected a member of the court of examiners in the vacancy occasioned by the retirement of Mr. Golding-Bird. Mr. Pearce Gould, F.R.C.S., Surgeon to Middlesex Hospital, and Mr. William B. Paterson, F.R.C.S., Dental Surgeon to St. Bartholomew's Hospital, were re-elected members of the board of examiners in dental surgery.

Upon the recommendation of the committee of management it was decided to add Alleyn's School, Dulwich, to the list of institutions recognised by the examining board for instruction in chemistry and physics. The balance sheet and statement of receipts and expenditure for the past collegiate year, submitted to the council by the Finance Committee, was approved and adopted, and it was decided to publish the statement of receipts and expenditure as usual in the college calendar.

A letter was read from the honorary secretary of the British Dental Association communicating the following resolution adopted at the annual general meeting of the association held at Cardiff on May 18th, 1907: "That any resolution, prescribing 'not less than two years' instruction in mechanical dentistry,' instead of three years as heretofore, is seriously detrimental to the efficiency of the profession." It was decided to refer the same to the court of examiners to consider and report.

The secretary having reported the death of Professor Edward Hallaran Bennett, of Dublin, an Honorary Fellow of the College, the president informed the council that he had conveyed to Mrs. Bennett the sympathy and condolence of the council, and a letter from Mrs. Bennett was read thanking the council for their sympathy in her bereavement.

The Institute of Hygiene.

Lord Robert Cecil held a reception at the Institute on Friday evening last, which was largely attended by members of the medical profession. Both the exhibition and lecture hall were very crowded at times, but the guests found much to interest them in examining the various foods and beverages on exhibition, as well as in the demonstrations of new appliances and machines in the hospital section. Among those who accepted the invitation were:—Dr. Appleby, Dr. Anderson, C.I.E.; Mr. Arthur Barker, Sir William Bennett, K.C.V.O.; Prof. Rose Bradford, M.D.; Mr. Jackson Clarke, F.R.C.S.; Dr. Leigh Canney, Colonel Drake-Brockman, F.R.C.S.; Dr. A. H. Payan Dawnay, Mr. T. J. Faulder, F.R.S.S.; Dr. W. Ewart, Mr. H. A. T. Fairbank, F.R.C.S.; Dr. Clement Godson, Dr. Griffith, Mr. Pearce Gould, F.R.C.S.; Professor Halliburton, M.D.; Sir Constantine Holman, M.D.; Dr. Havilland Hall, Mr. Arbuthnot Lane, F.R.C.S.; Dr. McLeod, Dr. Ogilvie, Mr Openshaw, C.M.G., F.R.C.S.; Dr. Steele-Perkins, Dr. Priestley, Mr. Mayo Robson, F.R.C.S.; Sir William Ramsay, F.R.S.; Dr. Sandwith, Dr. John C. Thresh, Mr. Tubby, F.R.C.S.; Mr. Arch. S. Vasey, F.I.C.; Professor Sims Woodhead, M.D., etc.

Action for Damages by a Medical Man.

At Leeds, on July 27th, before Mr. Justice Ridley and a special jury, was tried the action of "Rhodes v. Lancashire and Yorkshire Railway Company." This was a claim by a Dr. Rhodes, of Manningham near Bradford, for damages for personal injuries sustained in a railway accident at Lowmoor between Halifax and Bradford, on January 7th, 1907. The railway company did not dispute liability, and the issue tried was that of damages only.

The plaintiff stated that in the accident his head was violently thrown against the carriage. He suffered from severe pain in the lumbar region and sciatic nerve; he was unable to walk without great discomfort for a considerable period. He went for electric treatment to a hydropathic establishment at Southport during February; but, as he received very little benefit from this, he ultimately went on a voyage to South Africa. His practice averaged £400 a year, and it had suffered in his absence. He claimed £1,500 damages. The defendants called evidence to show that the plaintiff was much less seriously injured than he represented himself to be. Their medical witnesses were of opinion that the voyage to South Africa was unnecessary, and that the plaintiff not only would have been able to resume practice earlier than he did, but that he would have benefited thereby. It transpired during the course of the case that while the plaintiff was staying at the Southport establishment an official of the company stayed there and watched his movements.

The learned Judge, in summing up, commented strongly on this conduct, and said that in a case where it was clear there had been considerable injury it was very regrettable that the railway company had thought fit to employ a detective to spy on the plaintiff.

The jury awarded the plaintiff £600 damages.

Second International Congress of School Hygiene.

At the request of the King, Lord Crewe, Lord President of the Council, has consented to open the Second International Congress of School Hygiene on the morning of Monday, August 5th. While still adhering to their resolution not to issue official invitations to foreign Governments to send delegates, the Board of Education has arranged with the Foreign Office to take such steps as are likely to remove any misunderstanding which might prevent some foreign delegates from accepting the invitations issued. It is hoped, therefore, that all hindrances to the complete success of the Congress have been removed.

PASS LISTS.

Royal College of Physicians of London.

At the *comitia* of the Royal College of Physicians of London, held on July 25th, the President, Sir R. Douglas Powell, in the chair, the following were elected officers of the college:—Censors, David Ferrier, M.D., J. Mitchell Bruce, M.D., T. Clifford Allbutt, M.D., J. F. Goodhart, M.D.; treasurer, Sir Dyce Duckworth, M.D.; Emeritus registrar, Sir Henry A. Pitman, M.D.; registrar, Edward Liveing; Harveian librarian, J. Frank Payne, M.D.; assistant registrar, Oswald A. Browne, M.D.; Library Committee, Norman Moore, M.D., William Osler, M.D., H. D. Rolleston, M.D., A. Mercier, M.D.; curators of the museum, William Cayley, M.D., W. H. Allchin, M.D., S. J. Sharkey, M.D., and Dr. W. Hunter.

The following, having passed the required examinations, were admitted members of the college:—A. W. Falconer, V. S. Hodson, M.B., B. Hudson, M.A., M.B., L.R.C.P., H. C. C. Mann, M.D.Lond., L.R.C.P.; R. H. Miller, M.D.Lond., L.R.C.P.; H. Pritchard, M.D.Lond., L.R.C.P.; E. A. Ross, M.D.; G. M. Campbell Smith, M.A., M.D.; T. E. Tylecote, M.D. Vict.; S. A. K. Wilson, M.A., M.B., Edin.

The following were elected examiners in the subjects indicated for the ensuing collegiate year:—

First Examination.—Chemistry, J. M. Thomson, F.R.S., G. Senter, Ph.D., B.Sc; physics, Dawson F. D. Turner, M.D., A. W. Porter, B.Sc; materia medica and pharmacy, C. Ogle, M.B., J. J. Perkins, M.B., R. A. Young, M.D., J. P. Stewart, M.D., O. F. F. Grunbaum, M.D.; physiology, W. D. Halliburton, M.D., E. H. Starling, M.D.; anatomy, P. Thompson, M.D.; medicine, J. A. Ormerod, M.D., S. H. C. Martin, M.D., W. Collier, M.D., W. M. Murray, M.D., N. Dalton, M.D., H. D. Rolleston, M.D., Sir E. Cooper Perry, M.D., F. J. Smith, M.D., A. P. Luff, M.D., W. E. Wynter, M.D.; midwifery, J. Phillips, M.D., H. R. Spencer, M.D., W. J. Gow, M.D., T. W. Eden, M.D., G. H. D. Robinson, M.D.; public health, W. H. Wilcox, M.D., A. G. R. Foulerton, F.R.C.S.; Murchison scholarship, S. J. Sharkey, M.D., W. Hale White, M.D.

The Baly gold medal, instituted in 1866 by Dr. F. D. Dyster, of Tenby, "In Memoriam Gulielmi Baly, M.D.," which is awarded every alternate year on the recommendation of the president and council to the person who shall be deemed to have most distinguished himself in the science of physiology, especially during the two years immediately preceding the award, was awarded to Ernest H. Starling, M.D., F.R.C.P., F.R.S., Jodrell Professor of Physiology, University College, London.

Dr. James Ramsay, of York, presented the college with an autotype copy of a portrait of James Atkinson, 1759–1839, author of "Medical Bibliography," Letters A.-B. The thanks of the college were accorded to the donor.

On the recommendation of the committee of management the following institutions, which have been visited by a member of the committee and reported as fulfilling the requirements of the board, were added to the list of institutions recognised by the examining board in England for instruction in chemistry and physics:—The Municipal Technical School, Birmingham; Aldenham School, Elstree; Alleyn's School, Dulwich.

The following gentlemen, having conformed to the by-laws and regulations, and passed the required examinations, had licences to practise physic granted to them at this meeting:—S. H. C. Air, N. G. Allin, M. D. Anklesaira, R. E. Apperly, J. Appleyard, F. W. Aris, H. P. Aubrey, F. J. F. Barrington, R. L. Barwick, J. W. B. Bean, T. H. C. Benians, H. S. Berry, F. A. B. Bett, R. G. Bingham, J. W. Bintcliffe, F. R. Bray, A. Camacho, L. B. Cane, H. B. Carlyll, R. G. Chase, R. N. Chopra, F. Clayton, M. Cohen, F. G. Collins, P. C. Conran, R. N. Coorlawala, J. E. Copland, E. M. Cowell, A. J. Crawford, L. Croft, G. W. M. Custance, H. G. Daft, D. W. Daniels, W. Deane, H. C. Devas, W. C. M. Dickey, A. W. C. Drake, J. Duncan, J. E. Ellcombe, T. Evans, E. G. Foote, C. L. Forde, S. R. Gleed, E. S. Goss, H. Granger, W. B. Griffin, J. Hadwen, A. Hanau, W. W. Hellyer, *O. H. Hensler, T. S. Higgins, J. E. Hodson, G. Holroyde, A. E. Iles, W. A. M. Jack, W. J. Jago, A. G. Jenner, W. F. Jones J. L. Joyce, C. G. Kemp, *F. E. H. Keogh, S. M. Khambata, A. S. Khan, H. J. S. Kimbell, P. J. Kolaporewalla, C. F. L. Leipoldt, J. F. Lessel, J. R. Lloyd, J. J. Louwrens, L. G. J. Mackey, P. W. N. Mathew, J. E. Middlemiss, E. P. Minett, G. N. Montgomery, *E. Morris, H. W. Nicholls, H. Nockolds, F. W. O'Connor, H. P. Orchard, E. V. Oulton, R. C. Paris, J. G. Phillips, B. J. Phillips-Jones, A. H. Pollard, M. A. Rahman, J. Ramsay, A. B. Rooke, V. K. Sadler, *B. Saul, G. H. Sedgwick, G. A. Simmons G. M. Simpson, F. O. Spensley, S. F. St. J. Steadman, R. Y. Stones, E. Sutcliffe, R. S. Townsend, H. T. Treves, J. R. H. Turton, B. Varvill, H. F. Vellacott, W. G. H. M. Verdon, P. J. Verrall, S. Vosper, *F. J. Waldmeier, G. H. Watson, J. N. Watson, R. J. Willan, I. S. Wilson, J. F. Windsor, G. E. Wood, W. H. Woodburn, L. H. Wootton, O. K. Wright. (*Under regulations dated October 1st, 1884.

Royal College of Surgeons of England.

At the meeting of Council, on July 25th, the following candidates received the Diploma of Membership:—Samuel H. C. Air, Norman G. Allin, Manekjie D. Anklesaria, Raymond E. Apperly, James Appleyard, Frederick W. Aris, Harold P. Aubrey, Frederick J. Barrington, Richard T. Barwick, John W. B. Bean, Thomas H. C. Benians, Horace S. Berry, Raymond G. Bingham, John W. Bintcliffe, Frederick D. Bray, Angel Camacho, Leonard B. Cane, Hildred B. Carlyll, Robert G. Chase, Ram N. Chopra, Frank Clayton, Meyer Cohen, Francis G. Collins, Philip C. Conran, Rustom N. Coorlawala, James E. Copland, Ernest M. Cowell, Andrew J. Crawford, Lawrence Croft, Gustavus W. M. Custance, Hedley G. Daft, Davis W. Daniels, William Deane, Horace C. Devas, William C. M. Dickey, Arthur W. C. Drake John Duncan, John E. Ellcome, Trevor Evans, Edmund G. Foote, Cecil T. Forde, Seymour D. Gleed, Edward S. Goss, Henry Granger, Walter B. Griffin, John Hadwen, Alfred Hanau, William W. Hellyer, Oscar H. Hensler, Tom S. Higgins, John E. Hodson, Gerald Holroyde, Arthur E. Iles, William A. M. Jack, William J. Jago, Arthur G. Jenner, William F. Jones, James L. Joyce, Charles G. Kemp, Frederick E. H. Keogh, Sohrab M. Khambata Abdus S. Khan, Henry J. S. Mimbell, Phirozeshaw J. Koloporewalla, Christian F. L. Teipoldt, John F. Lessel, John R. Lloyd, James J. Louwrens, Philip W. Mathew, James E. Middlemiss, Edward P. Minett, Gordon N. Montgomery, Edward Morris, Harry W. Nicholls, Humphrey Nockolds, Francis W. O'Connor, Harry P. Orchard, Ernest V. Oulton, Robert C. Paris, John G. Phillids, Benjamin J. Phillips-Jones, Arthur H. Pollard, Mohamed A. Rahman, Jeffrey Ramsay, Alfred B. Rooke, Vyvyan K. Sadler, Barnett Saul, George H. Sedgwick, George A. Simmons, George M. Simpson, Frank O. Spensley, Sidney F. St. J. Steadman, Robert Y. Stones, Edward Sutcliffe, Reginald S. Townsend, Harold T. Treves, James R. H. Turton, Bernard Vasvill, Harold F. Vellacott, Walter G. H. M. Verdon, Paul J. Verrall, Sydney Vosper, Frederick J. Waldmeier, George H. Watson, John N. Watson, Robert J. Willan, Ivan S. Wilson, James F. Windsor, George E. Wood, William H. Woodburn, Leonard H. Wootton, Oswald K. Wright.

Royal College of Physicians and Surgeons.

The Diploma in Public Health of the Royal Colleges of Physicians and Surgeons was issued to the following candidates:—Isodore M. Bourke, L.R.C.P., M.R.C.S.; Edwin Eckersley, M.B., C.M.Edin.; Robert J. Ewart, F.R.C.S., L.R.C.P., M.D.Vict.; Matthew H. Fell, L.R.C.P., M.R.C.S.; Harry A. Foy, L.M.& S.Bombay, L.R.C.P.& S.Edin., L.F.P.& S.Glas.; Frederick W. Lewis, M.B.Lond.; William G. Liston, M.D., Ch.B. Glas.; Edward D. Parsons, L.R.C.P., M.R.C.S.; Wentworth F. Tyndale, C.M.G., L.R.C.P., M.R.C.S., M.B.Lond.; Brian Watts, L.R.C.P., M.R.C.S., M.D. Bruxelles; Bernard H. Wedd, L.R.C.P., M.R.C.S.; M.D.Lond.; James E. Wilson, M.B., B.Ch., R.U.I., Charles R. Wood, L.R.C.P., M.R.C.S., M.D., B.S. Durh.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

The quarterly examinations of the above Board, held in Edinburgh, were concluded on the 22nd inst., with the following results:—

First Examination (four years' course).—Mr. Thomas Kennedy, Belfast, passed the examination.

First Examination (five years' course).—Of 37 candidates entered, the following 17 passed the examination: John Richard Smith, Maneck B. Motafram, Hormusji J. Dadysett, Arthur Saldanha, Robson E. I. Mason, Victor G. L. van Someren, John Ross, Michael P. Power, David A. Evans, William J. H. Davies, Ernest J. Fisher, Andrew Hegarty, James A. Hutchinson, Satis Chandra Das, Harry C. Sutton, Frank D. Johnson, and Gajanan J. Nahimtura; and 6 passed in physics, 9 in biology, and 2 in chemistry.

Second Examination (four years' course).—Of 3 candidates entered the following 2 passed the examination: Michael J. O'Shea, and Richard B. Sephton.

Second Examination (five years' course).—Of 41 candidates entered, the following 18 passed the examination: Ernest B. Keen, John W. Hitchcock (with distinction), Charles B. Robinson, Thomas N. Usher (with distinction), George F. Neill (with distinction), Alfred F. Tughan, Rankin G. Walker (with distinction), Ralph C. Fuller, Robert H. Jones, Harold H. Field-Martell, Andrew D. Turnbull, Robert Massie, MacWilliams Henry, William T. Torrance, Robert M. M. Wilson, Syed Abdul Karim, Bertram Flack, and Isaac J. McDonough; and 4 passed in anatomy and 2 in physiology.

Third Examination (five years' course). Of 30 candidates entered, the following 17 passed the examination: John Young, Baldey Singh, Surendra Kumar Sen, Albert R. H. Harrison, George F. Ford, Thomas J. George, Edith Huffton, Marguerite Alice C. Douglas, Edmund Eccles, William Watson, Claude E. Watts, Francis S. Crean, James Morham, Harold A. Higginson, Lily Holt, Hormusji Jehangir Dadysett, and Gajanan Jinabhai Mahimtura; and 4 passed in materia medica.

Final Examination.—Of 54 candidates entered, the following 17 passed the examination and were admitted

L.R.C.P.E., L.R.C.S.E., and L.F.P. & S.G.: Ernest Fielden Nivin, Dennis Cregan McCabe-Dallas, William Alexander Huston, Lakshmi Narayan Ghosh, Richard Howard La Barte Cummins, Francis Ernest Robert Bartholomeusz, Thomas Richard McKenna, Samuel Jay Aanji Kotak, John Scott Ward, Oliver Carlyle, John Edmund Cox, John Arthur Cadman Tull, William Clegg-Newton, Thomas McClure, Rajanja Robert Williams, David Williamson Anderson, and Thirukamu Sundara Reddy; and 5 passed in medicine and therapeutics, 3 in surgery and surgical anatomy, 8 in midwifery, and 10 in medical jurisprudence.

The Royal University of Ireland.

THE Senate met on Friday, July 26th, at 11.30 o'clock a.m. There were present: The Right Hon. Lord Castletown, of Upper Ossory, C.M.G., Chancellor of the University; Sir Christopher Nixon, Bart., M.D., LL.D., Vice-Chancellor, Rev. William Delany, LL.D., Edward Cuming, M.A., Rev. Thomas Hamilton, D.D., LL.D., John R. Leebody, M.A., D.Sc., Michael F. Cox, M.D., Rev. William Nicholas, D.D., Sir Henry Bellingham, Bart., M.A., Right Hon. Lord Killanin, Sir William Thomson, C.B., M.A., M.D., Bertram C. A. Windle, M.D., D.Sc., F.R.S., Right Rev. Monsignor Mannix, D.D. Sir James C. Meredith, LL.D. and Joseph McGrath, LL.D., Secretaries. Apologies were received from Sir Thomas Moffett, LL.D., D. Litt, Sir John Banks, K.C.B., M.D., LL.D., Right Hon. John Young, M.A., Most Rev. Edward Thomas O'Dwyer, D.D., Bishop of Limerick., Rev. Nathaniel McA. Brown, J. Walton Browne, B.A., M.D., Richard W. Leslie, M.D., M.Ch., Charles E. Martin. The results of the recent examinations were considered and Passes, Honours and Exhibitions were awarded in connection therewith. The following returns, which show the progress of the University, as measured by the number of candidates for the Summer Examinations since 1902, were submitted:—

SUMMER, 1907.

	Entered.	Absent.	Retired.	Deprived.	Rejected.	Passed.
Matriculation ..	1,127	17	6	4	420	680
First Arts	693	10	1	1	253	428
Second Arts	513	9	1	2	123	378
B.A. Degree	179	10	3	–	68	98
First Engineering	39	3	–	–	9	27
Second Engineering	37	–	2	–	18	17
B.E. Degree	17	2	–	–	3	12
First Law	14	4	–	–	2	8
LL.B. Degree ..	6	–	–	–	2	4
LL.D. Degree ..	3	–	–	–	–	3
First Medical ..	93	4	6	–	25	58
Diploma in Public Health	1	–	–	–	1	—
	2,722	59	19	7	924	1,713

Corresponding figures in former years:—

1906 ..	2,515	70	20	6	749	1,670
1905 ..	2,313	71	24	1	732	1,485
1904 ..	2,184	67	19	3	636	1,359
1903 ..	2,012	55	14	3	567	1,473
1902 ..	1,902	55	17	5	589	1,236

It was unanimously agreed to confer the Degree of LL.D. *Honoris Causa* upon Sir Otto Jaffé, Knight, J.P., Belfast, in recognition of his valuable public services, especially in the cause of education; and the Degree of D.Mus. *Honoris Causa* upon Mr. W. H. Grattan-Flood, in consideration of his valuable musical compositions and his contributions to Irish periodic literature.

The following resolution was moved by Sir Christopher Nixon, Bart., Vice-Chancellor of the University, seconded by Rev. Dr. Hamilton, and passed unanimously:—

"That having regard to the injurious impressions produced by the adverse comments on the working of this University as a teaching and examining body, made in the report of the Royal Commission on University Education in Ireland (1903), and in that of the Royal Commission on Trinity College, Dublin, and the University of Dublin (1907), the Senate earnestly desires to bring under the notice of the Government the serious injury to higher education in Ireland which will result from any further postponement of the settlement of a question so vitally bound up with the intellectual and material progress of the country."

And the following were named as a deputation to wait on the Chief Secretary in reference thereto:—Right Hon. Lord Castletown, of Upper Ossory, C.M.G., Sir Christopher Nixon, Bart., M.D., LL.D., Rev. William Delany, LL.D., Rev. Thomas Hamilton, D.D., John R. Leebody, M.A., D.Sc., Alexander Anderson, M.A., LL.D., Right Hon. Lord Killanin, Bertram C. A. Windle, M.D., D.Sc., F.R.S., Right Rev. Monsignor Mannix, D.D.

It was agreed to fix October 22nd, 1907, at 4.30 o'clock p.m. for the next Annual Meeting of Convocation.

A meeting of the University was subsequently held at which the following Degrees were conferred:—Degree of Doctor of Laws, Samuel James Diamond, John Francis Butler Hogan, Charles James MacGarry.

The First Examination in Medicine.—Christopher Barragry, Daniel J. Barrett, John L. Brown, Peter A. Clearkin, Maurice J. Cogan, Ernest Colgan, Patrick J. Corcoran, John F. Craig, Thomas P. Davy, Joseph C. Denvir, Bernard Doyle, B.A., Gerald Fitzgerald, Thomas F. S. Fulton, Michael J. Gallagher, Joseph Gorman, M.A., Thomas D. Graham, Gerald S. Harvey, James Hill, Joseph O. Hodnett, Norman L. Joynt, Francis J. Keane, James J. Keirans, John L. Kilbride, James Lafferty, Hugh T. S. M'Clintock, Robert J. M'Connell, Laurence J. J. M'Grath, Michael M'Guire, Aloysius D. MacMahon, Robert C. M'Millan, Daniel M'Sparron, Cornelius Martin, William Megaw, William M. Millar, Alexander G. Mitchell, John J. H. Mitchell, Henry H. Mulholland, Henry J. V. Mullane, Daniel O'Brien, John P. O'Brien, James O'Connor, Thomas F. O'Donoghue, William M. O'Farrell, Joseph A. O'Flynn, Patrick J. O'Grady, Oriel J. O. O'Hanlon, Hugh O'Neill, Joseph Patrick, Joseph Porter, Joseph H. Porter, James M. Rishworth, Walter N. Rishworth, Maurice J. Roche, John M. Rowe, Hugh A. Skillen, Thomas Smyth, Francis J. D. Twigg, William Wilson.

Honours in Botany, First Class.—James J. Keirans, Ernest J. Colgan, Joseph H. Porter.

Second Class.—Michael M'Guire, John J. H. Mitchell, Joseph O. Hodnett.

Honours in Zoology, First Class.—Ernest J. Colgan, James J. Keirans.

Second Class.—John J. H. Mitchell.

Honours in Chemistry, First Class.—None.

Second Class.—James J. Keirans.

Honours in Experimental Physics, First Class.—Joseph O. Hodnett.

Second Class.—Aloysius D. MacMahon, James J. Keirans, Ernest J. Colgan, Hugh O'Neill.

Exhibitions.—First Class, £20.—James J. Keirans.

Second Class, £10.— Joseph O. Hodnett.

Diploma in Public Health Examinations.—Part I.—Stephen B. Walsh, M.B., B.Ch., B.A.O.

London School of Tropical Medicine.

THE following candidates have passed the examinations from May to July, 1907:—

With Distinction.—Captain F. H. G. Hutchinson, I.M.S., M.B., C.M. (Edin.), 1892, D.P.H. Camb., 1907; Captain W. S. Willmore, I.M.S., M.R.C.S., L.R.C.P., 1895; Captain J. N. Walker, I.M.S., M.R.C.S., L.R.C.P., 1897; A. W. Balch, Surgeon U.S. Navy, Ph.G. (Mass.) 1894, M.D. Harvard, 1898; C. A. Godson, I.M.S., M.R.C.S., L.R.C.P., 1904; F. Grenier (Colonial Service), M.B., C.M. (Edin.), 1891.

Ordinary Pass.—T. R. Beale Browne (Colonial Service), M.R.C.S., L.R.C.P., 1901; J. C. C. Ford (Colonial Service), L.R.C.P. and S., L.F.P. and S. (Glas.), 1900; G. Wilkinson, M.B., B.C. (Camb.), T.S.A., 1892; E. Weatherhead, M.B. (Camb.), 1903, M.R.C.S., L.R.C.P., 1903 (Colonial Service),

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

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Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

Civil Surgeon.—The last tabulated figures available that give the incidence of enteric fever in the army in South Africa are those for 1905. The average strength of European troops in South Africa for the year was 18,593 warrant officers, non-commissioned officers and men. Among this number there were 231 admissions for enteric fever, 17 deaths and a "constant sickness" of 43.60. The rate of admission was 12.4, the mortality .91. and that of "constantly sick" 2.35 per 1,000. These figures showed a marked decrease from 1904, for then the figures were admissions 29.5, deaths 3.79, and average "constantly sick" 6.21. There is even a greater decrease when these figures are compared with average for the three years immediately following the war, namely, 1902-1904. This average showed a decrease of admissions 16.5, deaths 2.48, and average "constantly sick" 3.35. The enteric fever in the army in South Africa last year, as a matter of fact, was less frequent and less fatal even than influenza, for that disease caused 622 admissions and 25 deaths.

Inquirens.—The whole subject is fully explained in Dr. Shaw-Mackenzie's book "On the Nature and Treatment of Cancer" (fourth edition), published by Messrs. Bailliere, Tindall and Cox.

Optician.—We cannot publish our correspondent's letter, inasmuch as the complaints made do not appear to be well founded.

Dr. A. B. J. is thanked for his communication; we will look into the matter, and give our opinion thereon in a private letter.

Dr. J. O. C. will find his communication referred to in another column.

Legend.—Our correspondent is thanked for his enclosure, which, however, is scarcely suitable for this journal.

F. A. B. (Liverpool).—Dr. Munro's "Manual of Medicine," a second edition of which has recently appeared, would answer your requirements exactly.

L. F. P. S.—We know of no official figures to show that trachoma is actually increasing in the East End of London. The disease is certainly an alien one, and should be guarded against by the inspectors at ports, and we know that immigrants are rejected on this score. The newspapers are breaking out into alarmist articles on the subject, but we have not yet seen evidence to show that there is more ground for alarm than there has been for some years past.

THE TREATMENT OF HAIRY MOLES.

Iota writes: In reply to "Query's" question about the treatment of moles, he may find painting the pigmented areas with ethylate of sodium effective. If carefully applied a scab forms on the area, which peels off without leaving much scar. Electrolysis will remove small moles and the hair-bulbs of hairy moles. Rontgen rays are disappointing.

From the "Gentlewoman."—A well-known physician (I can vouch for the truth of the story) was called out late one night to see a child. After entering into the minutest details with regard to the necessary poulticing and nursing, the doctor explained his intention of calling early the following morning. "Call, and will yer?" retorted the mother, arms akimbo, "and yer don't think our Willie's ill enough for medicine, that yer don't! By gad, yer can go, for I'll have a man that 'can doctor.'"

Vacancies.

Metropolitan Asylums Board.—Assistant Medical Officers. Salary, £180 per annum, with board, lodging, and washing. Applications to The Clerk, Metropolitan Asylums Board, Embankment, London, E.C.

Devon County Asylum.—Assistant Medical Officer. Salary, £140 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent, Exminster.

Zanzibar Government.—Bacteriologist. Salary, £300 a year, with free quarters, etc. Applications to Mr. A. W. Clarke, Foreign Office.

County Asylum, Mickleover, Derby.—Junior Assistant Medical Officer. Salary, £120 per annum, with furnished apartments, board, washing, and attendance. Applications to Dr. Legge.

Newport and Monmouthshire Hospital—Secretary and Superintendent. Salary, £200 per annum. Applications to the Chairman, Newport and Mon. Hospital, Newport, Mon.

Royal Lancaster Infirmary.—House Surgeon. Salary, £100 per annum, with residence, board, attendance, and washing. Applications to the Secretary.

Stockport Infirmary.—House Surgeon. Salary, £100 per annum, with board, washing, and residence. Applications to the Secretary.

Whitehaven and West Cumberland Infirmary.—Resident House Surgeon. Salary, £120 a year, with board and lodging. Applications to Wm. H. Sands, Secretary.

Loughborough and District General Hospital and Dispensary.—Resident House Surgeon. Salary, £100 a year, with furnished rooms, attendance, board, and washing. Applications to Thos. J. Webb, Secretary.

Taunton and Somerset Hospital.—House Surgeon. Salary, £100 per annum, with board, lodging, and laundry. Applications to Reginald A. Goodman, Secretary, Hammet Street, Taunton.

Liverpool Royal Southern Hospital.—Resident Pathologist and Registrar. Salary, £100 per annum, with board and residence. Applications to the Superintendent.

Staffordshire County Asylum at Stafford.—Assistant Medical Officer. Salary, £150 per annum, with furnished apartments, board, and washing. Applications to the Medical Superintendent.

Plaistow Fever Hospital, London.—Second Assistant Medical Officer. Salary, £100 per annum, with board, etc. Applications to the Medical Superintendent, Plaistow Hospital, London, E.

The Cambridgeshire, etc., Asylum.—Second Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors, 18 Emmanuel Street, Cambridge.

Appointments.

Boycott, A. E., M.D., B.S.Oxon., Gordon Lecturer on Pathology at Guy's Hospital.

Collie, R. J., M.D., C.M.Aberd., a Medical Referee under the Workmen's Compensation Act, 1906, to be attached to County Court Circuit No. 43.

Cope, V. Zachary, M.D., B.S.Lond., Resident Medical Officer at the British Lying-in Hospital.

Kerr, Harold, M.D., Ch.B.Edin., D.P.H.Camb., Assistant Medical Officer of Health of the City of Newcastle-upon-Tyne.

Jones, Richard, M.B., M.S.Edin., D.P.H.Camb., Medical Referee under the Compensation Act for the County Court Circuit of Blaenau Festiniog and Portmadoc.

Leslie, W. Murray, M.D., M.S.Edin., Medical Referee under the Workmen's Compensation Act in the City of London.

MacMyn, J., M.D., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Kirkcudbright District of the county of Kirkcudbright.

Paul, V. G. J., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Harwich District of the county of Essex.

Pearse, T. F., M.D.Brux., F.R.C.S.Eng., M.R.C.P.Lond., D.P.H., Health Officer to the Corporation of Calcutta.

Births.

Dru Drury.—On July 23rd, at Grahamstown, Cape Colony, the wife of Edward Guy Dru Drury, M.D., B.S.Lond., of a son.

Rowe.—On July 21st, at 260 Woodborough Road, Nottingham, the wife of W. T. Rowe, M.D., B.S.Lond., of a daughter.

Marriages.

Archibald—Riddle.—On July 25th, at Holy Trinity, Upper Tooting, Richard James Archibald, M.R.C.S., L.R.C.P., of Wandsworth Common, London, and Ramsgate, to Gertrude Florence, eldest daughter of F. H. Brimble-Riddle, of Upper Tooting.

Collingridge—Klein.—On July 24th, at St. Stephen's, East Twickenham, William Rex Collingridge, M.R.C.S., L.R.C.P., of Morland, Penrith, elder son of Dr. and Mrs. Collingridge, to Sybil Florence, elder daughter of Dr. and Mrs. E. Klein.

Juler—Chamberlayne.—On July 25th, at St. Peter's, Witherley, Frank Anderson, eldest son of H. Juler, Esq., F.R.C.S., of 23, Cavendish Square, London, to Mabel Alicia, eldest daughter of S. B. H. Chamberlayne, Esq., of Witherley Hall, Atherstone.

Langley—Ryder.—On July 27th, at St. Peter's Church, Dulwich Common, George Johnson Langley, M.D.Lon., eldest son of George R. Langley, of Camberwell Green, to Mabel Rose, daughter of the late Walter Greenway Ryder, and of Mrs. Ryder, of Dulwich.

Murray—Bott.—On July 24th, at St. John's, Paddington, Kenneth G. V. Murray, P.W.D., Egypt, youngest son of Surg.-Lt. Col. John Murray, A.M.S. (retired), of 12, Astwood Road, London, to Muriel H. H. Bott, daughter of the late John Bott and Mrs. Bott, formerly of Cheltenham.

Deaths.

Fowler.—On July 20th, at East Suffolk Hospital, Ipswich, Charles Breame, M.R.C.S., L.R.C.P., son of the late Lieut.-Colonel B. W. Fowler, R.A.M.C., and of Mrs. Fowler, of Bedford.

Moor.—On July 24th, at Branscombe, Guildford, Sarah, widow of late W. H. Moor, M.D., aged 68.

Watson.—On June 15th, at his residence, in Queenstown, Cape Colony, Alexander Lawrie Watson, M.A., M.B., Ch.B., son of George Watson, Esq., Alloway Park, Ayr.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, AUG. 7, 1907. No. 6

NOTES AND COMMENTS.

School Hygiene Congress.

THE assembly in London of the Second International Congress on School Hygiene is an event of no little importance, for it marks in some degree the fact that the British people who are credited with being possessed of a business-like faculty, consider that it is worth their while finding out something about this new science. Mr. MacKenna has given out that many of the decisions of the Board of Education are being reserved till he has ascertained the views and experience of the medical educationalists attending the Congress, and for this peculiarly backward Board to have grasped that school hygiene is not a mere fad for the delectation of doctrinaires and busy old maids, but a practical science on the development and application of which much of the future of the country depends, is a sign of hope for the rising generation or, at any rate, for the next rising generation but one. Moreover on the various Committees of the Congress are to be found many excellent people who already recognize that though school hygiene has none of the glamour of politics nor the advertising advantages of philanthropy—as frequently practised—yet that it is in itself an object, and a worthy one, of patriotism. And perhaps most significant of all is the willingness of hard-headed business men who have no immediate concern with the public health as usually understood, to give large sums to the expenses of the Congress, in order that the industrial and commercial prosperity of the country may be maintained, and their own profits thereby kept up. Assuredly then, when science, philanthropy, and commerce are found coquetting under the bland ægis of the Government, we may feel that the birth-right of a fair healthy start in life is likely at some time to become the possession of the proverbial happy English child.

The Municipalised Medical Man—

IT is curious as showing the tendency of the public thought at the moment to notice which of the papers read at the British Medical Association meeting at Exeter is most extensively noticed and commented on in the general press. Apart from the President's excellent address, this honour seems to have been accorded to Dr. Arthur Newsholme's communication to the State Medicine Section, in which he spoke of the whole trend of things at the present time being towards the establishment of a municipal medical service. That undoubtedly is true, and it is a part of the municipalisation of many industries which has been going on so rapidly of late years to the alarm of the financiers, and to the comfort of the poor and lower middle classes, whose necessities were frequently exploited without compunction. But it is a far cry from the municipalisation of water and gas to the municipalisation of the medical attendant, and though for attendance on the poor such an official may eventually develope out of the friendly society and club doctor of to-day, it is not in human nature as at present constituted to take the doctor that is forced on you by the State when you can afford to pay for one of your own choice. Dr. Newsholme thinks that the increasing number of cases treated in voluntary and rate-aided institutions is only a phase in a movement which will end in the proper treatment of all diseases at the expense of the community; and indeed the municipal fever hospital, which was originally founded as a preventive measure, is now used in some towns for the treatment of consumptives, and the isolation hospital itself, which was originally designed for paupers is now universally used for all classes, generally without fee.

And the Municipal Hospital.

BUT, however much the municipal, communal, or socialistic solution might relieve the problem of medical attendance on the poor of its worst features, such a system would necessarily connote the annexation of the hospitals as well, and it certainly is a question whether the people generally are sufficiently educated yet to run a hospital with all its varying interests. Naturally, they would insist, and rightly insist, on the treatment of the patient being the first consideration, but they would be exceedingly apt to overlook the educative and scientific functions of a hospital. The facilities for both these purposes at the present moment in all popularly governed medical institutions, if the pathological departments of some of the asylums be excepted, are either very poor or nonexistent, and unless democracy were much better instructed in the value of pure learning than it is now, there would be great danger of its overlooking the value to humanity of the clinical laboratory, pathological research, and the criticism of students.

A "Return" Case and its Result.

As an example of the incapacity of people to comprehend the unfortunate limitations of medical practice, we may instance the chronic troubles that rage about fever hospitals and "return" cases. At the present moment a wordy warfare is raging at Wolverhampton, on account of one of these unlucky events. One of the magistrates in that town, Mr. C. Marston, is, in what he considers the public interest, vigorously championing the case of one of his employees who with his son caught scarlet fever from a child discharged from the municipal fever hospital. The discharged patient had been detained six weeks in hospital and seems to have undergone the usual preparation prior to leaving the institution. He, however, developed nasal discharge shortly afterwards and infected his father and brother with the disease. Such unfortunate mishaps are so common that all instructed persons have learned to regard them as normal and unavoidable features of fever hospital administration, but to the lay mind they present the elements of unpleasant surprise and the conviction that there must have been want of proper care and supervision. Consequently columns of the local paper are occupied with polite recriminations between the Mayor, the Medical Officer, and Mr. Marston, and public sympathy seems to be on the side of the non-official. Such occurrences would be multiplied a thousandfold were all hospitals and medical services municipalised.

Death of William Rae.

Last week William Rae, the "bloodless surgeon," died at the age of 67. It is only two years since he sprang into fame in the curious line he selected for himself, and since the boom of the summer of 1905, which converted his village of Blantyre into the "Lanarkshire Lourdes," very little has been heard of him and his doings. It is due to him, however, to say that a large number of floral offerings were sent to his funeral by "grateful patients," although it seems from the accounts that an almost equally large number of people were disappointed at his death because they were still "awaiting cure." We may at least charitably suppose that Rae himself believed in his own powers, and that he became intoxicated with the credulity and enthusiasm of his clients, but it sounds rather curious to learn that "Rae's practice, it is believed, will be taken up by his son, a sturdy dairyman, who has shown some of his father's genius." As a matter of fact the force of personality is never better shown than by the break down of the "systems" of quacks as soon as the originator passes away. We venture to predict but little success for the "sturdy dairyman" unless he indeed possesses the "genius" of the miner surgeon, his father.

LEADING ARTICLES.

ACCURACY OF THOUGHT IN MEDICINE.

The address in medicine at the Exeter meeting of the British Medical Association was entitled "A Plea for Accuracy of Thought in Medicine." The fact that it was delivered by Dr. Hale White is sufficient guarantee of a wise and masterly treatment. At first sight it would appear that to plead for greater accuracy of thought in medicine would be simply to admit that the science in question has not yet reached finality. For in a certain broad sense all progress in science depends strictly upon greater accuracy in estimation, in comparison, and in all other methods whereby adequate knowledge of facts and of the relations of facts is obtainable. Medicine is not an exact science, inasmuch as it has to deal with many as yet imperfectly understood laws and phenomena, and is obliged to trust to many imperfect methods of investigation. So that the medical man has to be as accurate as he can in regard to many things and to adopt as a working theory that which appeals to his judgment as being most in conformity with ascertained facts. Dr. Hale White however, shows that medical men often deal intellectually with many things daily before them in a loose and slipshod intellectual fashion. He instances gout, in which we know that urate of sodium is deposited in some cartilages and other structures, and that there is an excess of uric acid in the blood. We speak of gout, bronchitis, neuralgia, sciatica and so on, but where are our proofs in the shape of a sufficient number of accurate *post-mortem* observations? Many obscure symptoms are referred to irregular or suppressed gout, whatever that may mean. Would it not be better to speak out boldly and say we do not know rather than beat the air with nebulous phrases that serve to cloak our ignorance? The candour thus advocated is clearly an attribute of the really scientific mind, but to advise a constant assertion of nescience would be to most medical men a counsel of perfection. It may be doubted whether even a man so secure in professional eminence as Dr. Hale White could carry out that attitude for any length of time in his relations with students, with the medical profession, and with his patients. To inspire confidence is one of the first essentials of practice and the man who lacks a certain amount of dogmatism is apt to be a failure both as a teacher and as a consultant, or as a practitioner, if he be in general practice. Another illustration of inaccurate reasoning was taken from the treatment of chronic osteo-arthritis, which being an affection of the joints more or less resembling gout, is sometimes treated with the restricted diet appropriate for gouty patients. Then we are reminded that peripheral neuritis due to alcohol is wont to attack the anterior tibial nerve in women. We accept the statement of fact and for the rest we calm our intellectual activities into self-satisfied repose with the blessed Mesopotamian word "selection." Yet it is difficult for a medical man who has been pressed into a corner by the cross-examination of "intelligent" patients to offer any truer explanation, because as yet none is known to science. The doubt that may reasonably exist as to the exact state of the cardiac muscle in a given case may in future be to a great extent avoidable by the use of the ortho-diagraph. The introduction of more accurate methods of investigation clearly gives us the data of more accurate thinking, the desirability of which must be evident to all who cultivate science. One point raised by Dr. Hale White is of considerable importance, namely, the way many medical men have of dealing with statistics, often laboriously collected, while they have failed to grasp the fundamental principles of statistical science. When trying to estimate the surgical mortality after operation for impacted gallstone for instance one must remember that impacted gallstone rarely causes death. During 40 years at Guy's Hospital there was only one death in a case not operated on, the total number of deaths from all causes being over 30,000. Mr. Bland-Sutton taking statistics from various London and provincial hospitals finds that out of 35 cases operated upon ten died, or nearly 30 per cent. Before we decide, therefore, that a patient should be advised to seek relief in operation, we have to consider carefully the high mortality that is entailed. Of this address it may be said that in itself it constitutes a valuable and suggestive object lesson in simple, clear and well-balanced reasoning.

CITY METHODS OF PHILANTHROPY.

The great world of medical philanthropy is doubtless working out its salvation by a species of evolution in which the struggle for existence leads to a certain amount of wasteful rivalry and of unfair competition. The hospital funds that have come into existence throughout the Kingdom bid fair sooner or later to establish some sort of reasonable control over the medical charities of which they are primarily the distributing and collecting agents. At present the chief defect of the funds, metropolitan and provincial, lies in the fact that they are not representative, as they should be, of subscribers, of the medical profession, and of the public generally. The result is that small boards of management seek to thrust private fads upon the charities that fall within the scheme of their distribution of grants. To take a recent instance, the Metropolitan Hospital Sunday and the King Edward VII. Funds have insisted upon the amalgamation of the orthopædic hospitals, regardless of the terms of existing charters or constitutions, or the sacrifice of valuable freehold sites. A similar policy of amalgamation, however, is not forced upon the ophthalmic or the throat hospitals, which abound in London and which are surely just as suited for amalgamation as the orthopædic institutions. But what have the Funds to say to the cripples' institutions ? Were there not enough existing already in the Metropolis without the addition of another by Sir William Treloar ? Why should not the great sums he has collected with indomitable vigour have been devoted to the extension and consolidation of pre-existing charities of the kind ? But consistency does not appear to be a guiding principle of the Metropolitan Funds. There can be little doubt that the large amount collected by Sir William Treloar during his year of office has diverted not a few subscriptions from other medical charities, so that in a sense his efforts are open to general criticism. That his aims are noble and his enthusiasm worthy of admiration may be at once admitted, but in the great social world purity of motive is not permitted to put a stop to criticism. Now Sir William Treloar has again and again stated that his institution is the only one in England in which tuberculous diseases of bone in children are subjected to systematic surgical treatment. That assertion has been naturally called into question by those connected with the Liverpool Country Hospital, which was founded ten years ago for that very purpose. A correspondence between the Chairman of the Liverpool Hospital and Sir William Treloar has been published. Notwithstanding that the facts were brought to Sir William's notice first on the 4th of June, and subsequently affirmed again and again, we nevertheless find a letter from the right honourable gentleman was published on July 14th, repeating the statement, which was reiterated at the Queen's Fete. Sir William Treloar, we feel sure, cannot have meant to act ungenerously to any institution, however much he may have been carried away by the ardour and enthusiasm of his own work. For all that the Funds if they are to press forward their amalgamation schemes, will do well to look into the question of the cripples' homes.

CURRENT TOPICS.

Mr. Haffkine and the Indian Government.

We have had on several occasions to draw attention to the treatment meted out by the Government of India to Mr. Haffkine *post* or *propter* the Mulkowal disaster. Whatever they thought or suspected at the time, there is in view of the evidence now before them nothing left for an honourable body of men but to apologise handsomely and unreservedly. In June there was issued, as a Parliamentary paper, the whole of the documents and reports relating to that untoward affair, and those who are acquainted with the value of evidence, especially if they have a working knowledge of bacteriology, will have no hesitation, we apprehend, in completely exonerating Mr. Haffkine from any suspicion of blame. In the *Times*, of July 29th, appeared a letter signed by Professors Ronald Ross, Tanner Hewlett, Albert Grünbaum, W. J. Simpson, Leith, W. R. Smith, Sims Woodhead, Klein, Simon Flexner (of New York), and Hunter Stewart—surely as representative a body of pathologists as could be named—in which the opinion was expressed that "the whole charge against Mr. Haffkine's laboratory has collapsed, the charge being not only not proven, but distinctly disproven." The signatories proceed to point out the petulance of the conduct of the Indian Government in evading this issue, and yet imputing blame to Mr. Haffkine for abandoning the "standard" method of making the prophylactic and substituting a new process "on his own authority." The cynicism of this charge fades away into most delicious impertinence when it is remembered that Mr. Haffkine invented the prophylactic himself, and taught the Indian Government how to manufacture it, and was continually improving it for their benefit. The fact is that the Government have made a hideous error by fastening on the wrong man when wishing to fasten on to somebody; now they have done more, they have acted snarlishly as they felt the ground slipping from under their feet. Is it too late to hope that the officials who now represent the Government will take the manly or honourable course of making what reparation and apology they can to Mr. Haffkine?

Breathing Appliances in Mines.

The Royal Commission on mines, which has been sitting for some time, has presented a preliminary report dealing chiefly with breathing appliances. It is discouraging to find that this country, which depends for its prosperity so largely on mineral wealth, is so far behind other civilised nations that whereas in Austria and France the use of breathing appliances is compulsory, and in Germany their employment is general; yet in Great Britain, except at the Tankersley Collieries in Yorkshire, they seem to be regarded as mere scientific toys. It appears from the report that in Westphalia these appliances have been shown to be so advantageous to the employers in the case of fire and flooding of mines, that they have been universally adopted, and the workers themselves thus, through an indirect channel, get the security they afford. After testing a good many appliances the Commission have come to the conclusion that though there have been great improvements in the latest patterns, no one type is to be recommended for compulsory adoption, but they hope that the mine owners will adopt some one of the best patterns without delay. It is recommended that neighbouring collieries should group themselves into areas having a central rescue station, and that special men should be trained by practice in rescue work to use the appliances. It seems not a little odd that whereas divers have for years been supplied with air while they work under the sea, an invention to preserve the life of workers in foul gases is only just coming to the fore. At any rate it may be hoped that mine owners will not need any further stimulus to adopt this means of protecting and rescuing their workers, now that the Royal Commission has shown its practicability.

Medical Arrangements on American Liners.

At this time of year the cross-Atlantic liners are crowded with throngs of passengers. Each year sees a considerable increase in this traffic, which has now assumed such gigantic proportions as to tax the resources of the shipping companies to the utmost. On the other hand, considering the golden harvest that is reaped from it, no class of traffic paying steamships like their passengers, it is a matter for some surprise that the arrangements for the comfort and well-being of their clients are not above suspicion. We have heard of several complaints of a more or less disquieting nature, but without better evidence than has been forthcoming it has not been advisable to notice them. However, last week a correspondent of the *Pall Mall Gazette* again drew attention to the subject, and we gather from his article that the rush and scurry on some of these liners is so great, and the medical arrangements so haphazard, that great discontent prevails among passengers. It surely is a serious reproach to these great lines with their floating palaces if this be indeed so. The tradition, of course, at sea is that the doctor and his department are quite subordinate considerations, and in the past when a comparatively small number of passengers were carried, things were muddled through somehow. But when three or four thousand souls are on board a ship the medical responsibility is very great, and we should have thought that the medical officers would have been provided with the amplest accommodation for the reception of the sick, and with staffs sufficient for all emergencies. No doubt it would attract passengers greatly to know that a highly efficient medical service was available on a particular line, so that apart from humanitarian reasons, it ought to pay any company commercially to make such provision. But in the meantime it is pitiful to learn that the Italian Government are so dissatisfied with the arrangement made by the companies for their subjects that they send an official medical man of their own to see that things are properly looked after on the voyage.

A Pharmacy Prosecution.

A recent prosecution in Glasgow under the Pharmacy Acts revealed a curious state of affairs. The defendant was accused of calling himself a chemist and of keeping open shop and dispensing poisons both personally and through an unqualified assistant, although he was not a duly registered pharmaceutical chemist. It appeared from the evidence that he went to this shop 27 years ago, and after five years of managership took over the business on the death of the proprietor. During those 22 years nobody had ever interfered with him. On the passing of the Pharmacy Act in 1868 he had applied to be registered, but his application was refused. His lordship characterised the offence as serious because the Act was passed for the protection of the public, and he imposed fines to the extent of £9 13s. in all. This accident suggests that it would be well to supervise the qualifications of practising chemists periodically in all parts of the United Kingdom. The offence of "covering" is not unknown, neither is that of personation. Indeed, *mutatis mutandis*, much the same sort of evasion is probably practised in the case of medical qualifications. In every legally recognised profession it is necessary to devise some efficient control with maintenance of a register, but probably only the lawyers have anything like proper machinery for the purpose.

Camphor Eating.

There seems to be some remote prospect that camphor eating may be added to the list of drug habits that have been imported into the United Kingdom. So far, however there is no particular reason to dread the prevalence of so dangerous a craze, any more than that of morphia, or Indian hemp, or chloral, or other drugs that have figured on the list for years past. In South America camphor eating is said to be fashionable, its victims exhibiting diminished will power and shattered nervous and circulatory system common to the prolonged abuse of narcotic drugs. Camphor is credited with bringing a particular disaster upon its victims in the shape of general paralysis. The drug in question is prescribed much more commonly in America than in our own country, and it is possible that this fact to some extent accounts for the greater frequency of camphor eating on that side of the Atlantic. At any rate, we refuse to believe that the practice has gained any real foothold in the United Kingdom. It is always difficult to get direct evidence as to the actual facts and figures of a particular drug, and as a rule the investigator is forced to trust to the reports of the markets to show that the consumption of some particular drug has undergone a considerable increase.

Disinfecting Dangers.

A death from chlorine gas poisoning occurred recently in Manchester under somewhat curious circumstances. An elderly man was engaged by the Gorton District Council in Whitsuntide last to disinfect a house formerly occupied by a person suffering from an infectious disease. He used for the purpose chlorate of potash crystals, and hydrochloric and carbolic acids. During the process he inhaled some of the fumes, and developed an illness which proved fatal some ten weeks later. Medical evidence showed that bronchitis and laryngitis were present and that the condition was primarily due to the inhalation of the fumes. The incident points to the necessity of proper skill in the application of gaseous disinfectants, of which chlorine is probably by far the most irritating and deadly. Sulphurous acid is not only safer, but easier to use and cheaper, facts which quite account for its popularity. The death above alluded to took place before the new Compensation Act came into operation otherwise the Council would have been responsible for the occurrence. The possibility of death from disinfectant fumes should be widely known, and most certainly work in connection with irritants and dangerous gases should never be entrusted to anyone who does not possess the requisite skill and special knowledge.

The Notification of Disease.

The article by Dr. McWalter, published in our issue of the 31st ult., contained suggestions deserving of serious consideration from those interested in questions of public health. It is quite true, as Dr. McWalter points out, that there is a general assumption that the only diseases a medical officer of health is expected to check are those known as zymotic. This is a very narrow view of preventive medicine, but one which is tacitly gaining the field. The fact that it is only the zymotic diseases which are officially brought to the notice of the health authorities is doubtless one of the reasons for this strange narrowing of vision. Dr. McWalter suggests, therefore, a widening of the present system of notification, or rather the adoption of an entirely new method. His plan is that every practitioner should at regular intervals furnish the health authority of his district with a full list of the diseases under treatment, The list need not contain the names of the patients, so that no question of breach of confidence could arise. As a result of such information the sanitary authorities would be in possession of full knowledge as to the state of their districts at any moment. It is of interest that a similar system to that suggested is already at work in Buenos Ayres and various other cities.

An Anti-Vaccinist Mare's Nest.

His anti-vaccinist friends will hardly be very grateful to Mr. Lupton for his question last week to the President of the Local Government Board regarding an alleged death from vaccination at Croydon, since it gave Mr. Burns the opportunity of exposing another anti-vaccinist mare's nest. It has been stated, and Mr. Lupton repeated the charge, that a child had died at Croydon, on April 29th, as a result of vaccination; that the child had sores on the head, face, and arms, and had lingered in agony for three months. Fortunately, in the interests of truth, an investigation of the facts had been made by Dr. Copeman of the Local Government Board, and, consequently, Mr. Burns was able to contradict Mr. Lupton's statement to the fullest extent. The sores from which the child suffered had no relation to its vaccination, but were in fact the result of over-dosage with bromides, a drug administered in large quantity by the child's mother, on account of fits from which it suffered. Some twenty other children had been vaccinated with the same lymph as this child, none of whom had suffered from any untoward symptoms. Moreover, it does not appear that there was any foundation for the statement of the length of the child's illness, or even that the illness had been fatal. We could wish that more of the "platform facts" of the "anti-vacs" could be brought to the test of question and answer in the House of Commons.

PERSONAL.

Mr. Henry Morris, P.R.C.S., unveiled the Jubilee memorial window in Epsom College Chapel at the annual celebration of Founders' Day on July 27th.

Dr. R. P. Strong, of the American Bureau of Science, has been exonerated after enquiry by a special committee of the charge of inoculating Filipinos with cholera virus.

Dr. T. Outterson Wood has been presented by the staff and committee of management of the West-End Hospital for Nervous Diseases with a handsome silver bowl on the occasion of his retirement from the post of Senior Physician. Dr. Outterson Wood has been appointed Consulting Physician to the hospital.

H. S. H. Prince Alexander of Teck, G.C.V.O., presided on July 20th at a general meeting of the Special Appeal Committee of the Royal Waterloo Hospital for Children and Women. He announced that the building debt had during the last four years been reduced from £30,000 to less than £1,000.

Dr. Hector Mackenzie will open a discussion on the "Complications and Sequelæ of Pneumonia and the Treatment of Pneumococcal Affections by Serum or Vaccine" at the Royal Society of Medicine, on October 22nd next.

Lord Selby has been able to resume his duties as chairman of the Royal Commission on Vivisection. The Commission has now adjourned for the summer vacation.

A Clinical Lecture

ON

THE TREATMENT OF SUPPURATIVE OTITIS.

By R. H. WOODS, M.D., F.R.C.S.I.,

Surgeon for Diseases of the Throat, Nose and Ear to Sir Patrick Dun's Hospital.

The obscurity which surrounds some diseases of the ear and the neglect with which otology has been treated by those responsible for medical education in this country, have so deterred medical men from paying proper attention to the subject that many practitioners do not differentiate between those maladies that may be easily understood by anyone with a surgical training, and those that still puzzle the most advanced otologists.

Now it so happens that pyogenic diseases, from a public health point of view those of the greatest importance, come under the former class ; and it naturally follows that since they are better understood they can be better treated. A few words on the subject of suppurative otitis media may, therefore, not be out of place.

It will be convenient in the first place to draw a picture of a typical case of purulent otitis, and then see in what way the less typical ones vary from it.

Suppurative otitis may have its origin in a variety of ways. Among the more commonly observed are the following :—

1. As a complication of febrile attacks, especially where the fever is due to, or accompanied by inflammation of the membrane of the throat and nose, *e.g.*, measles, scarlatina, influenza.
2. From a chill such as follows exposure to a cold blast impinging on a small part of the body, as happens, for instance, when sitting in a warm room near an open window.
3. From mechanical violence such as a box on the ear, or plunging into water from a height.
4. From using the nasal douche or blowing the nose very hard, where, in addition to more or less mechanical damage, septic or other irritating material is forced into the tympanic cavity along the Eustachian tube.

From whatever cause arising, the sequence of events is the same in the vast majority of cases. The patient is seized with severe, deep-seated throbbing pain and a sense of fulness in the ear, accompanied with some febrile disturbance. This lasts in an untreated case from a few hours to several days. During this time, fluid, dark-coloured serum, is poured out from the swollen mucous membrane into the tympanic and accessory cavities.

If the attack is mild the quantity will be small and the swelling of the mucous membrane will not be great enough to prevent the exudation finding its way along the Eustachian tube. In all but the mildest cases, however, the fluid is exuded with increasing rapidity and the Eustachian tube becomes more and more obstructed by the swelling of its lining membrane, the pressure of the fluid in the tympanic cavity increases until the membrana tympani ruptures, and with the escape of fluid into the external meatus the patient gets relative relief. It will thus be seen that the interval of time between the onset of the attack and the rupture of the drum is chiefly a question of the severity of the attack.

From being at first reddish and serous, the discharge after a day or two changes its character, and becomes purulent or, more properly speaking, mucopurulent.

Two courses are open to an ear in this condition. The discharge may diminish and in a week or two finally cease and the perforated drum heal up ; in which event we call the case one of acute suppurative otitis media ; or the discharge becomes fœtid and continues indefinitely when it is called chronic suppurative otitis media. What is the essential difference between the two varieties, and what is it that determines to which class the case is going to belong ?

Some ten years ago, I undertook an investigation to help to clear this point. In an epidemic of measles and scarlatina lasting over five months 319 patients were admitted to the Hardwicke Hospital. I daily examined the ears of each of these patients. Many of them inflamed during the course of the general disease, some already had chronic purulent discharge.

I found that all the acute cases had this in common, viz., that only one kind of organism was present in the pus, while the pus from chronic cases invariably contained a great variety. This led to the generalisation that all cases of ear suppuration are acute at first, and only become chronic by being re-infected through accident, or want of proper precautions.

That this is the essential difference between acute and chronic middle-ear abscess is further borne out by the fact that it is the rarest thing to see a chronic otitis established in a case where proper treatment is carried out from the onset.

The object of treatment in such cases should then be to avoid this epi-infection by preventing extraneous organisms from becoming implanted in the tympanic cavity, or, to use a word suggested by a medical man, himself a sufferer, to keep the cavity monoseptic.

While it is probable that the external auditory meatus is not sterile, yet it is more likely that this secondary infection occurs when the tickling induces the patient to remove the discharge and allay the irritation with the tip of his finger The pus thus becomes inoculated and as it decomposes, the bacteria spread along it and gain access to the drum and mastoid cells.

The first step in the prevention of this transition from acute to chronic is the frequent removal of discharge by syringing. To accomplish this apparently easy task one or two points are worth bearing in mind. In the first place, it is more important that the fluid used should possess a solvent action on the muco-pus than that its germicidal power should be high. Therefore an alkaline solution is indicated, and I am in the habit of advocating bicarbonate of soda solution (ʒij. ad Oj.). This will emulsify and remove the discharge better than an acid or neutral one, and it has the great advantage in out-patient practice that it is inexpensive and handy. The syringe should have a fine nozzle, so that the size of the stream is small as compared with the lumen of the meatus. Only by this means can we be sure that the fluid searches the inner end of the meatus. It should be so easy to manipulate that the point of the nozzle can be held in front of the posterior wall of the cartilaginous meatus without risk of its slipping inwards and injuring the drum. For these reasons I have found an ordinary rubber enema-syringe with a fine ear-nozzle, most suitable, especially when, as is usually the case, the treatment has to be carried out by someone with no special training at the work. Glass syringes are inefficient on account of their small capacity and dangerous from the difficulty of holding them properly. The only objection to the rubber syringe is its price, which is sometimes prohibitive to the very poor.

When the meatus is thoroughly cleared of discharge it should be dried. The next step consists in introducing some drug into the meatus which will have the effect of inhibiting the growth of bacteria in the meatus. It matters very little what form this takes; an insufflation of boric acid is very good, but it needs an insufflator, and even then the powder may not go as far as it is intended to go. My own practice has been to put the patient lying on the opposite side, and to fill the ear with a saturated solution of boric acid in equal parts of rectified spirit and water, and allow a quarter of an hour to elapse before letting the drops run out. A little of the solution will remain behind, and even after the spirit and water evaporate, the boric acid has crystallised out and mixes with the fresh discharge, when it again begins to flow.

Neglecting tuberculous otitis, which is, of course, chronic from the first, if we want to prevent a chronic otorrhœa from being established, it is therefore only necessary to ensure that the ear be attended to once or twice daily by removing the discharge and impregnating the meatus with some unirritating drug having an inhibitory effect on the growth of bacteria.

For the prevention of acute otitis, it is most important that adenoids, when present, should be removed, as from their low vitality they favour inflammatory attacks which may spread to the ear along the Eustachian tube. Nasal douching should be avoided whenever possible, and under no circumstances carried out in any but the gentlest manner.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by G. H. Savage, M.D., F.R.C.P., Consulting Physician for, and Lecturer on, Mental Diseases, Guy's Hospital; Examiner in Mental Pathology, University of London. Subject: "The More Recent Treatment of the Insane."*

Probably the oldest medical man in the United Kingdom on the list of consulting physicians to a hospital is Sir Henry Pitman, who has passed his ninety-ninth birthday this month. Sir Henry graduated M.B. sixty-seven years ago, and commenced his long connection with St. George's Hospital half a century ago.

ORIGINAL PAPERS.

A PLEA FOR ACCURACY OF THOUGHT IN MEDICINE. (a)

By W. HALE WHITE, M.D.Lond., F.R.C.P.

Senior Physician Guy's Hospital, &c., &c.

It seems to me that sometimes we retard the progress of our science by being afraid to say we do not know. All human beings desire to find explanations. This is laudable, but it should not lead us to such hasty greed that we swallow false explanations which do us more harm than good, for then we resemble the unreasoning thirsty child who drinks salt water. Wrong explanations may be worse than none, because many people accept them comfortably without stopping to enquire if they are reasonable; but if no explanation was in the field, some thinkers would devote themselves to the problem which they now pass by, being soothed by the false interpretation, as, indeed, physicians were for the centuries during which the humoral doctrines prevailed.

It might be thought that, in the present scientific age, the habit of being content with rubbish in place of an explanation was a mental malady that had left us, just as the dancing mania of the middle ages has departed; but I am afraid we sometimes show symptoms of it. Accumulated observation and experience have taught us a great deal about gout, but all we really know of its pathology is that urate of sodium is deposited in some cartilages and other structures, and that there is an excess of uric acid in the blood. Nevertheless, often, instead of boldly saying to ourselves we do not know the cause of many cases of neuralgia, sciatica, bronchitis, and several other diseases, we set them down to gout; but where are the figures from the post-mortem room showing that urate of sodium is excessively frequently found in the cartilages or fibrous structures of, for example, people suffering from sciatica, or that they have an excess of uric acid in their blood? If we think accurately, we ought not to say a person has gouty sciatica unless we believe that he has urate of sodium in some of his cartilaginous or fibrous structures, or an excess of uric acid in his blood, and that these facts are etiologically related to his sciatica. Further, we ought, as a result of the experience of ourselves or others in the post-mortem room, to have such good evidence in support of our belief that we should not feel our reputation for skill in diagnosis seriously damaged if the patient were killed on the spot and no urate of sodium or excess of uric acid were found. Some, perhaps, feeling the impropriety of calling these conditions gouty on such slender evidence as others deem sufficient, and yet susceptible to the Mesopotamia-like soothing influence of words, irrespective of their meaning, have said: Here are a number of symptoms we cannot explain; we do not think they are due to gout, but let us imagine that the gout is irregular, or atonic, or undeveloped, or suppressed, and then we can ascribe them to it. In passing, the thought arises, if gout is undeveloped or suppressed, how can it cause symptoms? This method of nomenclature is worthy of Gilbert and Sullivan, but, seriously, is it creditable? As Sir Dyce Duckworth says: "Without doubt, many morbid states have often been flippantly or erroneously set down to irregular gout which owned no such designation, and thus a cloak for ignorance has always been at hand to throw over careless observation, ignorance, or wilful misinterpretation of symptoms." But others have gone further on the slippery downward path reached by the habit of jumping to conclusions, instead of saying we do not know, for they have not only declared that patients have irregular gout, but have linked it to one of the only certain pathological facts we know about true gout, and so have ascribed the symptoms of irregular gout to an excess in the blood of uric acid or bodies allied to it. Some do this without knowing the amount of uric acid present in the blood of a healthy person, without drawing any distinctions between endogenous and exogenous uric acid, without any attempt to estimate the uric acid in the patient's blood, without any experimental evidence that the injection of uric acid into the blood produces the symptoms in question, and without any thought of the fact that in some forms of leukæmia there is an excess of uric acid in the blood without the symptoms supposed to indicate suppressed gout. This doctrine has become so widespread that even the public tell us that their symptoms are caused by an excess of acid. Having assumed, not proved, that the symptoms the patient has are due to irregular gout, and having assumed, not proved, that this is due to an excess of uric acid, the next assumption made is that certain foods cause an excess of uric acid—some say carbo-hydrates, some say fats, some say proteids—and it would be quite easy for a patient to consult three doctors in turn, and, if he followed all, his diet would be water and nothing else. He who believes proteids harmful is the most artistic, for he has an eye to colour, and may as a concession allow white meat, although he prohibits red. Where on earth is the justification for this? Are there any experiments showing that steak leads to more uric acid in the blood than chicken? Have a hundred cases of so-called irregular gout been published and contrasted with another hundred similar in their treatment, except that in one series red meat was replaced by an equal amount of white? Surely you will agree with me that all this is not a credit to us as members of a scientific profession. The simple fact that although gout has become much less common, the consumption of meat has enormously increased, ought alone to make those who forbid proteids pause. The imagination of some has carried them still further. The fact that both gout and chronic osteo-arthritis are long-lasting diseases of joints has led them to think that as sufferers from one should be dieted, so those afflicted with the other. Hence we find patients who have chronic osteo-arthritis forbidden various articles of food, sometimes, for example, sugar. Looked at calmly, this is extraordinary, for there is not an atom of evidence that any particular article of food influences chronic osteo-arthritis.

(a) Abstract of Address in Medicine, delivered at the Exeter Meeting of the British Medical Association, 1907.

Sometimes we attempt to pacify this dislike to acknowledge that we do not know, by words which do not really help us at all—in fact, by lulling us into the belief that they explain facts when they do not, they lead us to imagine that our knowledge has rock for its foundation, when in truth it is built upon sand. For example, a teacher tells his students that alcohol is the cause of the peripheral neuritis from which the woman before him is suffering; but in saying this he fails to explain the remarkable facts that the disease is commoner in women than in men, and picks out the anterior tibial nerves before any others. There must be something different in the nerves of women from those of men and of the nerves in women the anterior tibials must be different from the others. Now, is the opportunity for the soothing influence of words; instead of being helped to face these facts as inexplicable in the present state of our knowledge, we are told that alcohol has a selective action upon these nerves especially in women, just as lead is said to have a selective influence on the musculo-spinal nerves. But does this help us? Surely not. It merely restates the fact that is evident to everybody; it is no explanation, but only an attempt to befog us with words and so possibly to retard the true explanation.

One of the greatest discoveries ever made in medicine will come to pass on the day when the mysteries now concealed by the phrase "selective action," are made plain, and we understand why, for example, the rash of measles comes first on the forehead; that of the scarlet fever on the chest; that of typhoid fever chiefly on the abdomen; and why, of all nerves in the body, the poison of diphtheria is specially harmful to those supplying the palate and the ciliary muscle.

Want of time prevents my bringing forward other instances of the years of delay in arriving at a truthful diagnosis that follow from cowardice in acknowledging that we do not know the cause of many symptoms; but it would not be difficult to do so, especially from among chronic diseases of the joints and diseases of the heart. I notice at the present time an increasing tendency to consider the muscle of the heart to be at fault; I believe that in the past we have not considered this nearly as much as we ought, and probably we have often overlooked disease of the cardiac muscle, but, unless we check our clinical work by histology, we run great danger of believing disease of the cardiac muscle to be present when it does not exist. I think I could show that the heart has often been said to be feeble or dilated on insufficient grounds, and the orthodiagraph will, I think, teach us that we have frequently been in error when we have thought the heart altered in size, just as the clinical use of the manometer has taught us that the estimation of the arterial tension by the finger is not so accurate as we have been inclined to believe.

He is the best physician who spends much of his time in the post-mortem rooms, and is not afraid to say he does not know. But the inability to make this confession is not peculiar to our profession. Since I drew up this address I have come across the following from the pen of Sir Alfred Wills:—"A constant source of difficulty in judicial investigations lies in what seems almost like an ineradicable tendency of human nature—an impulse to appear to know everything about occurrences of which the witness in reality knows but a part, and often a small part. . . . It seems to require some moral courage to say, "I don't know." It is not that the witnesses mean to deceive, but they have reasoned out what they never really observed, and confound the impressions so produced with those of actual observation." With doctors the temptation not to acknowledge they do not know is particularly strong, for patients are often so insistent upon an explanation that they thrust one upon the unfortunate doctor. Let us hope that they will do this the less as general education improves.

Talking of unwillingness to confess our ignorance, leads us to think of instances in which, while trying to treat medicine scientifically, we are woefully inaccurate, because we make excursions into sciences in which our training is inadequate. For example, the light and airy way in which some of us play with figures, as though there were no science of statistics, is astounding. Professor Karl Pearson truly says: "Approaching pathological inheritance from the modern statistical standpoint, it is almost heart-rending to notice the great amount of effort and energy wasted in the collection of data bearing on the inheritance of disease, but, unfortunately, much effort and energy have been thrown away upon other medical statistics, besides those connected with inheritance."

It must be left to expert statisticians to reform technical errors, but it is easy to indicate a few that are obvious. Frequently the mistake is made of dealing with far too few figures; often the very data are wrong, as we have just seen in connection with the hæmatemesis. Allowance is rarely made for the number of persons alive at different ages; it is very common to see figures published believed to prove the effect of this or that treatment without any allusion to the rapidity of recovery if no treatment had been adopted, and often the figures do not tell us what we desire to know. For example, statistics are published showing the frequency of recovery after some difficult operation. In the first place, for these to be of any practical use, we want to be able to contrast them with figures showing the mortality among those not submitted to operation. We ought to compare the expectancy of life among those who are not operated upon with that of those who submit to operation, for it is clear that if the operation considerably shortens the life of many, the total harm done by the operation may be more than the total good. Then, again, although it is interesting to know the degree of perfection to which any particular surgeon can carry the difficult art of operating, and so lower the mortality, yet, as all the patients cannot possibly go to the one skilful man, it is far more important to know the usual mortality among operating surgeons. These are only some of the points we have to consider, but let us take as an illustration the operation for a gall-stone impacted in the common duct. When trying to estimate the propriety of this we must bear in mind that when impacted in the common duct a gall-stone rarely causes death. From the years 1854 to 1894, only one patient not operated upon died in Guy's Hospital from an impacted gall-stone, the total number of deaths from all causes having been over 20,000. Naunyn has only once known the condition fatal. Some distinguished surgeons have operated upon several cases with complete success, but on the other hand, Mr. Bland-Sutton, doing the right thing and taking the figures not only of an individual surgeon, but from the chief London hospitals, and the Leeds and Newcastle Infirmaries, finds that out of 35 cases operated upon, 10 died, or nearly 30 per cent. But it might be urged that, bearing in mind the risk of fatal cholangitis and the tediousness and discomfort of passing an impacted gall-stone naturally, it is worth while to submit to operation, but before coming to this conclusion we must proceed very carefully, considering the high mortality following operation. Further, it is notoriously difficult to distinguish between an impacted gall-stone and malignant disease, so that in estimating the benefit that follows operation, we must take into account the shortening of life, owing to operation, among those who are operated upon in the belief that they have a gall-stone, although they really have malignant disease.

Please let it be understood that I am not in any old-fashioned way objecting to the advances of surgery. Far from it. The debt that physicians owe to modern surgery is very great; every year hundreds of people whom we physicians are powerless to help have their health restored to them by surgeons, and my surgical friends know well that not a week goes by but that I seek their aid. Nor am I here attempting to decide whether gall-stones should be excised from the common duct. The sole reason why I have taken an example of an operation upon medical cases to illustrate the care which must be exercised before arriving at a conclusion derived from figures, is that it is easier to see the result of a surgical operation than that of other modes of treatment; but I can readily take an instance from medicine, namely, the treatment of typhoid fever by bathing. Many large collections of cases have been published showing that if all the patients whose temperature exceeds a certain point are bathed, the mortality is lowered, and from that fact it is argued that all patients whose temperature exceeds that point should be bathed. But this does not follow, for supposing the bathing killed some who would otherwise not have died, but saved more who would have died if they had not been bathed, the mortality would be lowered, although the treatment would have killed some. Surely the right thing to do is not to bathe all, but to select to the best of our judgment those who should be bathed.

But when we have got our figures, the problem is often much more obscure than any of those just quoted, and demands a special training in the use of statistics that few doctors possess. A good illustration of the extreme difficulty of dealing with medical statistical problems is the question whether tubercular disease is hereditary. Often the evidence is fallacious, as, for example, when the writer forgets that all experience gained in the post-mortem room shows that many have tubercular disease who, as far as we know, gave no evidence of it during their life. Even figures from life insurance societies dealt with by actuaries are not free from fallacies of evidence, for they can take no account of those who are born of tubercular parents and die of tubercular disease without coming up for examination for life insurance. Often the reasoning is fallacious also, as, for instance, it is stated that such and such a proportion of sufferers from phthisis have consumptive parents, forgetful of the fact that this is worth little, unless we know what proportion of people who have not got phthisis have consumptive parents, and, beyond obvious pitfalls such as these, there are others that only the expert statistician can avoid. A few years ago, when it was discovered that there could be no phthisis without infection by tubercular bacilli, many of the medical profession, without any careful consideration, threw overboard the belief that inheritance played any part, and it was maintained that the children of tubercular parents were not more liable than others to phthisis, but Prof. Karl Pearson has recently published a paper in which he states that the inheritance of a special liability to infection by tubercle bacilli plays a very important part. Much has been made of cases in which it appeared that phthisis has been transmitted from husband to wife or *vice versa*, but as a rule, no attempt is made to calculate the probability that both might have such a common disease quite apart from infection from one to the other, and, therefore, it is interesting to read that Prof. Karl Pearson says: "There is clearly no need in such cases to appeal to infection from husband or wife to account for the small number of cases in which both parents suffered." I am afraid that frequently we describe conditions as having a special association without any endeavour to determine whether they are more frequently associated than might he expected as a matter of chance. The statistics about insanity and cancer also show the extreme difficulty of a proper use of medical figures. I have often urged what I am glad to see he urges that, as to deal with figures requires a special training, which is enjoyed but by few of us, we should not draw conclusions from statistics unless we obtain the help of those specially educated to their use. But statistics are only part of a larger matter, namely, the extraordinary width of knowledge required for our science of medicine.

Yet another hinderance to the advance of medical knowledge is the acceptance of facts upon authority. Thus the hæmoptysis of phthisis was often ascribed to vicarious menstruation, although it occurs equally in men and women; it may be met with in females who are of such an age that menstruation does not take place, and it has no monthly periodicity; but perhaps the most striking instance of subservience to authority was the almost universal habit of bleeding solely because the teaching of the day said that people should be bled. Often patients were actually bled to death; yet those who did it were so blinded that they ascribed the death to the illness and not to the bleeding.

Not so very long ago, that extremely powerful poison, antimony, was given for many diseases because it was stated by authorities to do good. No one would now contend that any considerable proportion of the thousands of patients who took antimony were one whit the better for it. When a student begins his work he must for a little while accept some statements upon the authority of his teacher; but with every day of his career the necessity for this becomes less and less, for medicine is a science in which nature performs on every patient, experiments that those who have eyes to see can watch and so observe for themselves if the statements commonly made are correct.

Speaking of the use of antimony and venesection, as illustrating the harmful effect of authority, reminds us that no department of medicine shows this better than that which deals with treatment. Sometimes authority in one country advises different treatment from that employed in another. Thus, whilst in England we often give strychnine when the pulse is feeble, in Germany camphor is used for the same condition. This seems absurd, one or the other must be the better. Often little attention is paid to the natural course of the disease towards recovery; for example, many methods of treatment by drugs, electricity, serums or operation are said to benefit exophthalmic goitre, regardless of the fact that if the patient is put to bed and kept quiet, she will usually recover without any other treatment. With many diseases the natural tendency to get well is so great that, unless there is a strong consensus of opinion as to the efficacy of one particular mode of treatment, *e.g.*, iron for chlorosis, mercury for syphilis, thyroid for myxœdema, probably no special treatment by drugs does any good. It may be laid down that when more than two drugs are praised as benefiting any disease, probably no one that we know does so.

Unreflecting adhesion to authority has a particularly serious effect in keeping back the advent of correct knowledge, for, in the first place, when the authority is found to be wrong, much energy that might be utilised in the search for truth is expended in demolishing that which is false, and, in the second place it seems almost a law that we should rush to extremes of thought, so that having been for years wrong in one direction, we travel for years wrongly in another course, before attaining the true position. For example, for many years after it was shown that bleeding had been frequently practised for diseases in which it did harm, it was very rarely done, and many patients were, therefore, deprived of the relief it would have given them, and it is only now that we have learnt to correctly know when to employ it. "It is almost always the unhappiness of a victorious disputant to destroy his own authority by claiming too many consequences or diffusing his proposition to an indefensible extent."

Much of this excessive zeal for treatment by drugs arises not only from an unwise adhesion to so-called authority, but from a lack of appreciation that pathology is the basis of all medicine. The primary duty of a physician is to find out what is the matter with his patient; proper treatment can only be secondary to that. Another reason for incorrect treatment is that many say, "You must do something." I can never see the reasonableness of this. The very fact that the doctor does not know what to do is actually used as a reason why he should do something; surely it is the very reason why he should do nothing, for he may well do more harm than good. To know when to interfere and when not to interfere with Nature is a fine test of the sagacity of a clinical physician. Do not, however, imagine I am urging that treatment is rarely of use. Far from it. Never at any period in the history of medicine has treatment been more skilful than now, and never did out art save more lives than now.

The last point to which I have time to draw your attention is that it usually requires considerable trouble to train ourselves to receive new ideas properly, and by failing in this respect we retard the progress of medical thought. In this matter there are three kinds of mind. Those having the one usually claim that they are critical, but they are obstructive rather than fair critics. For the most part, they are extremely slow to assimilate anything new, strange to say they frequently pride themselves on this, and take great comfort from the sad fact that many suggestions which, when first promulgated, appeared fruitful have turned out to be barren. Those having the other are easily enticed away by new notions just because they are new; they absorb new ideas too rapidly without digesting them; in popular language they are ready to swallow anything. Fortunately, our profession contains many who fall into neither of these classes because they have an evenly balanced mind, trained to estimate the value of novel suggestions.

Pardon me for having in these fragmentary remarks only stated what you all know, and what many have taught at various times during several centuries. My excuse for urging a plea for accurate thinking is that the more accurately we think the more rapidly will medicine progress.

The Board of Governors of the Royal Hospital, Kilmainham, have selected Lieutenant-Colonel R. J. Windle, Royal Army Medical Corps, for the appointment of physician and surgeon to that Institution in succession to Lieutenant-Colonel F. S. Heuston, C.M.G., whose tenure will expire on September 30th.

THE CARE OF TUBERCULOUS CHILDREN. (a)

By T. N. KELYNACK, M.D., M.R.C.P.

Honorary Physician and Medical Adviser to the Children's Home and Orphanage; Honorary Physician to the Mount Vernon Hospital for Consumption.

Tuberculosis still remains one of the greatest scourges of child life. In the Anti-Tuberculosis Campaign it is essential for success that adequate provision should be made for the protection of infants and children from a tuberculous invasion and adequate means secured for the early detection and prompt treatment of all forms of tuberculous disease originating during the all-important initial years of life.

In the study of this question pathological considerations should receive attention. More than one-third of all deaths at the ages of 15 to 35 are from phthisis. Much of this mortality is the harvest of the tuberculous seed sowing in infancy and childhood. It is said that tuberculosis has increased about 20 per cent. among London children during the last fifty years. Of the 1,200,000 new lives added every year to the population of the United Kingdom from one-fourth to one-third are born to want and squalor, conditions making for tuberculosis. Tuberculous lesions are found in children under 15 years of age dying from all maladies in about 40 per cent. of the cases. Tuberculosis may be contracted during intra-uterine life, but is rare. An inherited predisposition of soil is certainly transmitted. Milk is probably an unimportant source of tuberculous infection. While agitating for hygienic control of our milk supply it is essential that the personal responsibility of parents and others in maintaining a healthy environment for the child should be insisted on. Von Behring's contention that tuberculosis is commonly acquired from tuberculous milk in France has not been substantiated, but his views regarding infection by tuberculosis in early life, its long latency in the glands of the abdomen and thorax, and its development when childhood's days have passed, are being supported by recent investigations and will go far to revolutionise theoretical conceptions and reform practical prophylactic measures.

Pulmonary tuberculosis occurs much more frequently in children than is usually believed. Professor Emmett Holt states that in nineteen months sixty-seven cases of pulmonary tuberculosis were under treatment in the New York Babies' Hospital, sixty-two under two years and fifteen under six months of age. By adopting a new method he was able to demonstrate the presence of tubercle bacilli in the pulmonary secretion in over 80 per cent. of the cases: the possibility of infection at home was known to have existed in at least 40 per cent.

Tuberculosis is met with among school children to an extent which demands serious attention. The promised medical inspection for public elementary schools should do much, if conducted by skilled examiners, in detecting the early evidences of commencing tuberculosis and in recognising children predisposed to tuberculous disease. Among the inmates of our Children's Home and Orphanage 25 per cent. are said to be the offspring of consumptive parents. Dr. Leslie Mackenzie states

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(a) Abstract of a Paper presented to the Section of Diseases of Children at the Exeter Meeting of the British Medical Association, Thursday, August 1st, 1907.

that 14 cases of pulmonary tuberculosis were noted among six hundred Edinburgh school children; and in three cases among Aberdeen children. Dr. William Robertson, of Leith, detected six cases of tubercle of the lungs among eight hundred and six school children. Dr. Alfred Greenwood, among one thousand and twenty-eight Blackburn children, specially selected by school attendance officers for medical examination, found that 6.2 per cent. were phthisical. Dr. Wilkinson, among seven hundred and nine Oldham children, found seventeen with pulmonary involvement, a percentage of 2.3. Dr. J. E. Squire, after an examination of nine hundred London children in one school in a very poor neighbourhood, places "the proportion of cases of possible tuberculosis of the lungs at about 1.5 per cent."

The late Professor Grancher found evidences of predisposition to tuberculosis in something like 17 per cent. of the Paris school children.

All schools should arrange for thorough medical examination with a view to the early recognition of tuberculosis and the detection of all tuberculously disposed children. The French plan of removing children from tuberculously contaminated homes has proved advantageous. There is need for an extension to this and other countries of the German Forest Schools for consumptive and tuberculously disposed children. This country is miserably poor in its provision for sanatoria for children. Urban hospitals for tuberculous cases are to be condemned. Institutions taking adult consumptives are not suitable places for children. Many of the supposed advantages of a marine situation for tuberculous children are in a great measure imaginary. Consumptive cases are certainly best dealt with at high and dry and sheltered inland stations. There is urgent need for co-ordination of knowledge and co-operation of practical effort. Individual benefit and national advantage would accrue from the founding of a National Society for the Study and Care of Tuberculous Children.

OBSERVATIONS ON THE

DETERMINING CAUSE OF THE FORMATION OF NASAL POLYPI. (a)

By EUGENE S. YONGE, M.D. (Ed.).

Honorary Assistant Physician, Manchester Hospital for Consumption and Diseases of the Throat.

The author's conclusions, which refer exclusively to *mucous polypus* of the nose, may be summarised as follows:—

(1) Mucous polypus may be regarded as a pathological condition possessing certain definite characteristics which distinguish it from other swellings and new formations that may occur in the nasal cavity. (2) Mucous polypus is essentially, and in its earliest stage, a patch of mucous membrane, which has become œdematous, the pedunculated appearance, which polypi commonly assume, being chiefly the result of physical causes acting on the primary patch of swollen œdematous mucosa. This tendency to become pedunculated is of course not peculiar to the condition in question, but is shared by many other intra-nasal new formations. (3) In the majority of instances the condition appears in both nasal cavities without any apparent local cause, which is sufficient to account for it. This circumstance, combined with other considerations, leads to the supposition that there is usually a constitutional element in its production which, together with certain local influences, is capable of setting in action that which is considered, by the author to be the proximate cause. (4) In a minority of instances there is present a condition (*accessory sinus suppuration*) which is a presumptive local cause of polypus-formation. But since this process does not necessarily lead to the production of the disease, and since the disease may occur without its intervention, it is reasonable to conclude that the process is instrumental in causing polypus-formation only when it sets in action the factor which is the actual proximate cause. (5) In a certain number of instances there have been observed changes of an inflammatory nature in the bone and periosteum, which would presumably be sufficient, if they were shown to be primary to the changes in the mucous membrane, to account for the incidence of œdema in that structure. But in view of the facts that in numerous specimens of bone, underlying polypi, no bone disease has been found; that polypi have been demonstrated to occur on a mucous membrane which shows only a superficial inflammation and in which the deeper parts are not diseased, and that the lesions in the bone, when present, have been shown by several observers to be secondary to the specific process in the mucous membrane, it may reasonably be inferred that bone-disease is not essential to the production of mucous polypi and that the primary œdema of the mucous membrane must ordinarily be referable to some other factor. (6) The *proximate cause* of the œdematous infiltration of the mucous membrane, which represents the primary and essential process of polypus-formation is in the author's opinion, the obstruction of certain definite capillaries and veins, brought about by a circumstance (dilatation of the ducts of the mucous glands, and, to a lesser extent, of their acini) which produces its specific effect by causing pressure on, and, probably, obliteration of the vessels, which surround the structures in question in the form of close networks. (7) An inflammatory process in the mucous membrane is a very common antecedent and accompaniment of polypus-formation, but since the former condition is obviously present in varying degrees of intensity and persistence, in a great number of cases which do not at any time give evidence of polypus-formation, it appears reasonable to suppose that inflammation of the mucous membrane does not of itself, lead to polypus-formation, but only does so by securing the intervention of another factor. The presence or absence of this factor (glandular dilatation) determines, in the author's opinion, whether an inflamed mucous membrane undergoes œdema and subsequent polypoid changes or whether it escapes such changes. (8) The evidence in favour of the contention that this particular factor sets in action the proximate cause which leads to the primary œdema, is derived from pathological, clinical and experimental observations.

Pathological.—(1) The frequent observation of distension and cystic dilatation of the glands in mucous polypi, and the almost invariable (a) presence of the condition (in the specimens examined) in the underlying and contiguous mucous membrane wherever this was œdematous. (2) The absence of the glandular changes in those instances of inflammation in which polypoid changes were not present. (3) The fact that an inflamed mucous membrane and one in a state of polypoid change appeared to show all residual circumstances in common except one — the glandular changes.

(a) **Abstract of Paper read before the Section of Laryngology and Otology at the Annual Meeting of the British Medical Association, August 1st, 1907.**

(a) **It is of course not necessary, from a logical point of view, that two circumstances should be in INVARIABLE association in order that an etiological relationship may be assumed, a FREQUENT conjunction being sufficient.**

Experimental.—(1) The fact that the production of an inflammatory process in the nasal cavity, in suitable animals, was not followed by any indication of polypoid change or of any distension of the glands. (2) That the production of an inflammatory process in similar animals, produced in the same manner, by similar agents and lasting for the same period of time, but combined with measures calculated to cause overloading and distension of the mucous glands, was followed by polypoid change in the mucous membrane, the latter showing marked distension and cystic dilatation of the glands on histological examination.

Clinical.—The author's hypothesis appears to offer an adequate explanation of the incidence of mucous polypi occurring under dissimilar circumstances and conditions. It is capable also of rendering intelligible the constitutional element that is evident in many instances; the common occurrence of polypi in cases where glandular disturbances are known to exist, and, at least in some instances, it helps to solve the question of recurrence. Moreover, the theory assists, in the presence of other known factors, in explaining the age-incidence; in reconciling the discrepancy between the incidence as observed *post mortem*, and the incidence as observed clinically, and lastly in explaining the localisation of polypi in special areas of the nasal cavity and in certain of the accessory sinuses.

THE CO-ORDINATION OF THE PUBLIC MEDICAL SERVICES. (a)

BY ARTHUR NEWSHOLME, M.D., D.P.H.

Medical Officer of Health, Brighton, &c.

THE following is a summary of Dr. Newsholme's paper in introducing the discussion:—The scope of preventive medicine is no longer confined to germ-born diseases, but extends to such early treatment of any disease as will secure a less severe or less protracted later stage of disease.

The community as well as the individual is interested in this wider definition of preventive medicine, though, as shown by the serious loss of life and health still due to avoidable causes, this is only partially realised. Poverty and disease act in a vicious circle, and the practical problem considered in this paper is the means by which people may be prevented from becoming poor by preventing them from becoming sick.

Official and voluntary agencies now at work show how much is already being done in the communal treatment and prevention of sickness. The list of these agencies given in the paper shows that the distinction between prevention and treatment has never been maintained. A rapidly-increasing proportion of total sickness is being treated in voluntary and in State or rate-supported institutions.

Are we getting a satisfactory return for this increasing burden on rates, taxes, and charity? Whether viewed from the standpoint of patients, doctors, or of the public health, the present state of the medical service must be condemned as unsatisfactory.

The conditions of private medical practice among the poor are admittedly most harassing and unsatisfactory to the doctor. To the patient they are equally unsatisfactory, for (1) diagnosis is belated, and (2) treatment is curtailed owing to expense. (3) In dispensaries, etc., there is a serious waste of time. (4) There are no co-ordinated arrangements for medical consultations. (5) Valuable information as to the incidence of disease is wasted. (6) There is a great waste of information as to the existence of conditions conducing to disease.

These defects can be overcome, as is seen in the co-ordinated arrangements where the notification of consumption is successfully at work. Thus the visit of an officer to the notified patients sets in operation all the prophylactic, curative and sanitary measures which are needed, equally for the welfare of the patient and of the public. Undetected cases are recommended for diagnosis and treatment. Sanatorium training and treatment are secured.

These defects are not overcome, for instance, when the organisation for the medical supervision of scholars is separate from the general public health administration of a district. Much of the medical inspection of scholars, if it is to be efficient, must be done by interviewing parents, and much of it involves home visits. The home is the point from which many of the evils discovered by medical school inspection will have to be attacked and controlled. In actual fact parents will not tolerate dual medical examinations for school purposes, and on the other hand neither school doctor nor medical officer of health fulfil the complete needs of the case. These will only be met when district doctors are appointed by each municipality, and these doctors are co-ordinated with the mechanism of preventive medicine, enabling us to secure the early systematic and unstinted diagnosis and treatment of all disease before, even more than at, school ages.

The present state of medical service is evidently transitional. Neither provident dispensaries nor cries against "hospital abuse" and "under cutting" practice have been able to hinder the steady progress towards the treatment of disease at the expense of the community; nor is it possible to arrest this trend. What has hitherto been done in the collective treatment of disease is merely a phase in the evolution of the system which will effectually ensure the early recognition and proper treatment of all diseases. Such a system would justify itself economically by the corresponding reduction of sickness and of inefficieny; in short, the justification of a municipal medical service both economically and medically consists in its being a branch of a general system of preventive medicine. By this means information of preventive value will no longer be allowed to run into *culs-de-sac* and be lost, preventive medicine being regarded as a whole, and its many fragmentary portions being no longer allowed to continue relatively impotent by being detached from single executive control.

A SMALLPOX case has been notified to the health authorities of Sunderland. The patient is a well-known merchant, who has just returned from a visit to Denmark, where he contracted the disease. He has been removed to the borough sanatorium.

(a) Abstract of Paper read before the Section of State Medicine at the Annual Meeting of the British Medical Association, Exeter, August 1st, 1907.

MILK IN RELATION TO HUMAN TUBERCULOSIS. (*a*)

By HENRY E. ARMSTRONG, D.Hy., Durh., M.R.C.S., L.S.A.

Medical Officer of Health, Newcastle-upon-Tyne.

THE Vehicles of Media by which the Bacillus of Tuberculosis gains entrance into the bodies of previously healthy human beings are the following, viz. :—

(*a*) The milk and milk-products (1), consumed as food, of tuberculous cows; (*b*) The milk of a tuberculous human mother; (*c*) The flesh of tuberculous animals consumed as food; (*d*) Dried expectorated matters and other infectious discharges of consumptive persons inhaled or swallowed as atmospheric dust, etc; (*e*) Heredity; (*f*) Marriage of the tuberculous; other vehicles, etc.

This division of the subject may be considered under the following heads, viz. :—

(1).—THE PREVALENCE OF TUBERCULOSIS AMONG DAIRY COWS.

The Report of the Royal Commission on Tuberculosis issued in 1898 states that "of all the animals slaughtered for food in Great Britain and Ireland those of the bovine race seem to be more largely affected with tuberculosis than any other." In the absence of statistical information as regards our own country the Report proceeds to show that in Leipzig, of 9,303 cows slaughtered, 4,048 or 43.51 per cent., were tuberculous. The proportion of such diseased cattle in the English cow-houses, which has been publicly and authoritatively stated at about 30 per cent. (MacFadyean) (2) may not be excessive. In the year 1901 there were 1,887,414 milch cows in England, and 4,102,061 in the United Kingdom.(3) Thirty per cent. of these means upwards of 560,000 tuberculous milch cows for England alone, and nearly 1¼ millions for the United Kingdom. The bare idea of the amount of possible human tuberculosis from the milk of so immense a number of diseased cows is appalling. Nothwithstanding this truly dreadful possibility the Report above quoted gives prominence to the following statement. "It is not proved to our satisfaction that tubercle bacilli has ever been detected in milk unless drawn from a cow with tuberculosis of the mammary gland."(4)

(2).—THE ENTRANCE OF TUBERCLE BACILLI INTO MILK, AND THE STATE OF MILK SUPPLIES IN RELATION TO TUBERCULOSIS.

In a well-known work(5) the means of entrance of uberculosis into healthy cowsis described, and may be summarised as follows :—(*a*) Tuberculous excretions and discharges conveyed to soil, air, water, fodder, and general surroundings (premises, stables, straw, stable refuse, utensils); (*b*) The milk of a tuberculous animal may be consumed by other animals; (*c*) The bacilli may be distributed by the cough of a tuberculous cow (Ravenel) or (*d*) by the saliva of a cow in licking In this way she may also infect the surface of her udder, and thereby the milk, by means of the hands of the milker.

Each or all of these ways may lead to the contamination of the milk after yield. By the repulsive habit of spitting on the hands before milking, or by dried expectoration in a cowhouse, a consumptive milker may infect the milk after it has left the teats of the cow.

The foul state of many cow-houses, both in town and country is only too well known, and ample illustration of this is on record.(6) It is right to add that of late years great improvement has taken place in many town cow-houses—but most of those in rural districts are as insanitary as ever. Dr. Hope, of Liverpool, has shewn that in town-yielded samples of milk the tubercle bacillus was found in 2.8 per cent., whereas in supplies sent from the country 29.1 per cent. were found to be tuberculous. Speaking from personal experience, the writer affirms that the cow-houses in Newcastle and the surrounding country districts are in much the same condition as in other places; and he has every reason to believe that a bacteriological examination of the different urban and rural milk supplies sold in the city would disclose results similar to those found in Liverpool and elsewhere. Even accepting the untenable hypothesis that cow's milk is only rendered infectious when the udder becomes diseased—the difficulty of diagnosing such disease at an early stage in time to prevent the use of the milk for food is so great as to put beyond the range of practical utility most of the apparent value of the suggestion.

(3).—THE EXTENT OF THE DISEASE CAUSED OR CAUSABLE BY MILK AND ITS PRODUCTS.

The milk trade is one of the most complex of organisations. Under defective management it may become a most elaborate means for the spread of different infectious diseases, and of none more frequently than tuberculosis. The fact that milk as sold to customers is the mixed yield of perhaps from 10 to 50 different cows—a certain proportion (perhaps a large one) of which are possibly tuberculous, renders the entire product, if so infected, a most potent agent of evil. As milk is distributed night and morning to the houses of dairy customers, by many of whom—especially the children—it is consumed raw, the opportunities of the dissemination broadcast of the virus of tuberculosis or other disease are far beyond comparison greater than with any other article of diet. The spread of infection from a diseased cow may go on for many months without detection, whilst her milk is being consumed without suspicion. That the many forms of tuberculosis among the young, and indeed among all ages. are not oftener traced to the milk-supply is the consequence not of the harmlessness of the milk itself, but of the complexity of the circumstances attending its distribution, together with the very nature of the disease and the conditions of its development. In the case of an outbreak of scarlet or enteric fever, of which there have been several hundreds within the last twenty years or so, the suddenness of the outburst, the nature of the ailment, the common routine of inquiry invariably made by the special inspector, and a host of other circumstances, point at the outset to the milk-supply as the possible, if not probable, cause. But, with tuberculosis this is not so. This disease is insidious in its approach; its period of incubation is unknown; the signs of its presence are for a considerable time indistinguishable from those of other ailments; and the means of tracing its probably remote origin are not available. Hence the impossibility in the present state of our knowledge of presenting evidence of the extent to which the disease may be attributed to milk or any other individual cause. This circumstance has led to the idea on the part of some that "if there had been anything like the danger from the meat and milk of tuberculous cattle that medical officers of health say there is, we should all have been dead of tuberculosis long ago!" Such an idea, if true, would apply to all infectious diseases, which would never cease until they had exterminated the entire human race. But they do not spread in this way for several well-known reasons which it is unnecessary here to state; and the same applies to tuberculosis, with respect to which it may be added that special predisposition on the part of some persons and exactly the opposite condition on the part of others, are special characteristics of that disease. It is stated on good authority that about 90 per cent. of the cases of tuberculosis among calves and swine have been proved to originate in feeding with infected milk.(1)

(a) Extract from the Report of the Medical Officer of Health, Newcastle-upon-Tyne, 1907.

(1) The term "milk products" includes, of course, butter, buttermilk, whey, and cheese.

(2) Trans. Brit. Cong. on Tuberculosis, 1901.

(3) Report of Royal Commission, p. 4.

(4) P. 13, s. 28.

(5) "The Bacteriology of Milk," Harold Swithinbank and George Newman, M.D, London, 1903.

(6) Report of Roy. Com. on Tuberculosis, 1898, ss. 45, 46.

(1) L. Rabinowitsch. Trans. Brit. Cong. of Tuberculosis, 1901 Vol III., p. 508.

(4).—THE DIFFICULTY OF RECOGNISING TUBERCULOSIS IN DAIRY CATTLE BY ORDINARY MEANS.

The difficulty of diagnosing tuberculosis by ordinary physical means at any but the most advanced stages of the disease is universally recognised; but this very fact is an element of the greatest mischief in the possibility it allows for the continuous spread of infection for a long period, from a diseased cow. Daily visitations at cow-houses afford but little information to the inspectors of the sanitary authority as to the health of dairy cattle.

(5).—THE TUBERCULIN TEST AS A MEANS OF DIAGNOSING TUBERCULOSIS OF CATTLE.

The Royal Commission of 1898 in their Report, s. 15, "recommended that funds be placed at the disposal of the Board of Agriculture in England and Scotland, and of the Veterinary Department of the Privy Council in Ireland, for the preparation of commercial tuberculin, and that stock-owners be encouraged to test their animals by the offer of a gratuitous supply of tuberculin and the gratuitous services of a veterinary surgeon on certain conditions."

"These conditions shall be:—(*a*) That the test be applied by a veterinary surgeon; (*b*) That tuberculin be supplied only to such owners as will undertake to isolate reacting animals from healthy ones; (*c*) That the stock to be tested shall be kept under satisfactory sanitary conditions, and more especially that sufficient air-space, ventilation, and light be provided in the buildings occupied by the animals."

The Commission further recommended the circulation among agricultural societies of instructions for the proper use of the tuberculin test, with explanation of the significance of reaction, and direction for effective isolation of re-acting animals.

The above recommendations are sufficient proof of confidence in the value of the tuberculin test. Although made eight years ago, so far as is known to the writer they *have led to no practical result whatever on the part of the British Government.* For this reason, and seeing the well known disinclination of farmers to speculation, and their not unnatural hesitation to experiment with the object of discovering disease in their herds, it is perhaps not surprising that the test has not become popular among them. The responsibility incidental to such a discovery may not be unconnected with their failure to adopt it. The magnitude of the task, and the claims for compensation involved have doubtless deterred the Government from pushing the subject forward on their part. Hence little or no progress has been made in England toward the elimination of bovine tuberculosis as a commercial project. Its compulsory extinction as a source of the greatest danger to human life has never yet, it is believed, been seriously proposed. What is the reason? "*If preventable, why not prevented?*"

(6) POSSIBILITY OF ELIMINATING TUBERCULOSIS OF CATTLE.

In reviewing the pros and cons of this momentous question the chief points for consideration appear to be the following:—(*a*) The tuberculin test is admittedly reliable as a means of detecting the disease; (*b*) Voluntary attempts to eliminate tuberculosis have been freely tried in Denmark and have met with a very large measure of success. To ensure complete success of the process compulsory and universally complete application of the principle is necessary; (*c*) The process of elimination should involve the immediate slaughter of all re-acters and the destruction of their carcases. Stock-owners should not be responsible for the carrying out of this great work for the public benefit; neither should they be at any pecuniary loss in its execution.

Fair compensation should be granted on compliance with requirements during a stated period whilst the process is in operation. Doubtless the knowledge of the sum of money that would be required for this purpose is the main objection to the enforcement of the measure by Government. Such an objection would not hold in the case of an acute and widespread epizootic or other disease, say of cattle plague, an outbreak of which in this country in 1865–6 involved the death of upwards of 233,000 head of stock. Here the first consideration was the stamping out of the disease as quickly as possible, and at any cost. Tuberculosis of animals is more widely spread than cattle plague has ever been; it is always chronically prevalent in our herds and dairies; whereas visitations of cattle plague are few and far between; and what is worst of all, it causes a vast amount of human sickness and death, which cattle plague does not do. Hence its distinction, both on hygienic and economic grounds, is more urgently called for than would be that of an epizootic disease of different kind. It is estimated that the disease in animals may be eliminated in a single year. It might be attacked in single counties or districts in successive years to diffuse over a longer period the cost of dealing with it. All fresh importations of cattle into a district after a given date should be subject to the test. If all stock-owners and butchers were required to purchase subject to guarantee against tuberculosis, as proved either by the tuberculin test or by inspection after slaughter, the test would rapidly become general. Owners would only be too glad to adopt it in self-defence, and other action necessary for the extinction of the disease would soon follow.

(7).—THE CONTROL OF THE MILK-SUPPLY BY SANITARY AUTHORITIES.

The control of the milk-supply of any district, to be satisfactory or complete, involves the necessity of frequent bacteriological examination of specimens drawn from the udders of each and all of the cows yielding milk for the supply of that district. This means that such examination should apply to the produce of dairies within the district and others sending supplies to it from without. A sanitary authority may take power to obtain the required specimens, and may carry it into effect in its own district; but to do so in the case of districts at a distance would be difficult and troublesome unless through the co-operation of the sanitary authorities of such districts. But under present conditions such co-operation is scarcely to be expected. For example: a large amount of milk is sent daily to London from Cheshire. Are the different rural authorities of the latter county to be expected to bestir themselves vigorously in order to condemn, in the interest of the distant metropolis, the cowsheds and milk-supplies of their own farmers, many of whom may be members of these same authorities? And how can London supervise the Cheshire dairies for itself?

The necessity for the regular and frequently repeated bacteriological examination of the milk-supply from every dairy cannot be too strongly insisted on. Tuberculosis of the udder is a well-known, though not by any means a common, form of the disease in cows, and the great danger in such cases of spreading the disease to consumers of the milk is admitted, even by the late Royal Commission, who cannot justly be charged with undue severity—at least to the dairy-trade—in their proposals for dealing with the milk of tuberculous cows, seeing that their protective recommendations extend only to animals with obvious disease of the *udder*, notwithstanding the fact that the milk of cows *without visible sign of tuberculosis of the udder* has been shown by many bacteriologists to be infectious.(1)

This systematic and general bacteriological examination of milk is all the more urgently required by the fact that dairy farmers are not yet compelled by law to take steps to ascertain whether their milch-cattle are all tubercle-free. The possibilities of spreading tuberculosis through the milk-supply are very great, inasmuch as in the case of one cow only having the disease in a large dairy-herd, her milk, mixed with that of the other cows, will contaminate the entire supply, which, being distributed twice a day for a lengthened period, and consumed largely by children and principally uncooked—whether in its natural state or in the form of butter or cheese—has thus greater possibilities for conveying infection than any other article of food. The ramifications of the milk trade throughout the United Kingdom are so complex and so intricate that no proper supervision in the interest of the consumer is at present practicable. Such supervision is possible only by the union of representatives of county councils and district authorities, both urban and rural, in one general body, with power to organise and cause to be carried out all such measures for the regulation of the production and distribution of milk as are required for the protection of the health of the consumers. The action of such a body need not by any means be limited to the control of the milk supply. In the national interest it might extend to the extinction of bovine tuberculosis, and other matters relating to public hygiene. The work for such an organisation is abundant, and if taken in hand will be found to increase year by year.

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(1) L. Rabinowitsch, 1901, and Swithinbank and Newman, 1903.

A sanitary authority should have power to collect at the place of production samples of any milk intended for sale within their district. No power is given to deal with any form of tuberculosis in a dairy, no matter how extensive, other than the comparatively rare one in which the udder is affected; and how is the dairyman to be proved to know that a disease of his cow's udder is tuberculosis? The application of the tuberculin test to dairy cattle, even in cases of suspected tuberculosis of the udder, is not provided for. The Liverpool milk clauses also fail to afford the protection against, and means of detection of, tuberculosis among the dairy cattle yielding the milk-supply for the city, which the public health demands. The medical officer of health may, it is true, by a very tedious and roundabout process, obtain an order to prohibit the sale of milk at any dairy, but *not unless he is of opinion that such milk has caused, or is likely to cause, tuberculosis to its consumers!* How, without previous application of the tuberculin test, is he to obtain the information on which to form such opinion? How long may the distribution of such milk have to continue to cause tuberculosis before the medical officer can possibly feel justified in concluding that it has done so? As it stands, the supposed "power" is a pure delusion.

(8).—Action Desirable.

Every sanitary authority should have the power to enforce, and should be required to enforce, the following provisions, viz.:—(1) to apply the tuberculin test to, and (2) to take such specimens as may be required of the milk of any cow, the yield of which is intended for sale in the district of such authority; (3) to prevent the sale of milk of any cow re-acting to the tuberculin test, or found to be affected with tuberculosis in any form whatever; (4) To destroy any dairy cow re-acting to the tuberculin test and to compensate the owner, in the event of his compliance with the requirements being approved by the sanitary authority; (5) to require that no fresh cow shall be brought into any dairy for the production of milk for sale that has not previously been recently tested with tuberculin and failed to re-act thereto.

The administration in detail of the foregoing and other requirements for the regulation of the milk trade ought, in the national interest, to be directed by a combination of sanitary authorities, as elsewhere indicated in the present report.

(9).—THE ATTITUDE OF THE LATE ROYAL COMMISSION IN RESPECT TO THE MILK OF TUBERCULOUS COWS, AND ITS CONSEQUENCES.

Among much that is valuable in the report of the Royal Commission of 1898, there is also much that is grievously disappointing. The observations on milk-supply (ss. 39 and 42) and recommendations 7 and 8 on the same subject are, as already stated, directed against the milk of cows with diseased udders only. The sale of the milk of other tuberculous animals is not condemned and therefore, by inference, is sanctioned by the Commissioners. In view of the abundance of proof as to the deadly nature of such milk, this is a lamentable fault in the report. As a whole, the sections of the report above referred to may, not inaptly, be characterised as milk and water.

The effect of the pronouncement of the late Royal Commission on their want of evidence as to the danger from the milk of a tuberculous cow, unless her udder was diseased, has naturally been to convey the general impression that the Commission did not regard such milk as dangerous, no matter how extensive the disease of the cow in the rest of her body—an admission only too likely to be taken as a rule for universal guidance. This opinion of the Commission is confirmed by subsequent sections (1) of the report, in which the protective measures recommended relate only to milk from cows with udder disease. That the conclusion of the Commission is absolutely incorrect and the doctrine advanced upon it dangerous to the highest degree, is proved by scientific evidence, part of which was before the world long before the sitting of the Commission, but of which they appear to have had no knowledge, and part of which was published subsequently. Thus Bollinger, in 1880, produced tuberculosis by innoculation with the milk of a cow whose udder was not tuberculous; Hirschberger (1889) found milk infective from a cow affected with slight tuberculosis of the *lung only* Ernst found in 114 samples of milk from 36 tuberculous cows, showing no udder lesion, that 28.57 per cent. were infective; Smith and Schroeder found the milk infective in two cases out of six; and Delépine found the same in five out of twenty-four tuberculous cows with no udder lesion.(2)

Again: ". . . The presence of tubercle bacilli in the milk of cows that respond to the tuberculin test without showing clinical evidence of tuberculosis was proved in the same year (1899) by the thorough experiments of Adami and Martin. A further proof in support of this theory was furnished by my last year's observations on milk supplied to infants in Berlin. . . The supply of milk taken from animals . . . contained tubercle bacilli though they showed no clinical symptoms of tuberculosis." (3)

(10).—LAW IN RELATION TO TUBERCULOUS MILK.

Special powers for dealing with tuberculosis and milk have been obtained by the authorities of Glasgow, Manchester, Liverpool (4) and many other English towns. Most of these powers, as ultimately granted, are based on the findings and recommendations of the Royal Commission of 1898, and for that reason alone, and others also, fall far short of requirements. The Corporations of Manchester and several other towns "sought limited power of inspection of the cows on all farms supplying them respectively with milk; and of exclusion of milk of cows with any form of udder disease or suffering from advanced (5) tuberculosis." These proposals were modified considerably by the Local Government Board, the Board of Agriculture, and the Associated Chambers of Agriculture and finally, the Corporations in question obtained the very limited power (1) to fine a dairyman who sold milk from a cow with a tuberculous udder, or continued to keep a diseased cow among other dairy cattle; (2) to require dairymen to notify tuberculosis of the udder.

Recommendations:

1.—With regard to Milk every sanitary authority should arrange for the systematic bacterial examination, and, as far as possible, the control, of the milk supply of its district.

2.—Every dairy farmer or producer of milk for sale should, before offering such milk for sale in any district, and whenever required by the sanitary authority of such district, satisfy such sanitary authority that the cattle yielding such milk are, each and all of them, free from tuberculous disease, as proved, after the application of the tuberculin test, by the certificate of the veterinary inspector of the district in which such milk is produced.

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(1) Ss. 39, 42, and 43.

(2) *Lancet*, January 20th, 1900.

(3) Dr. T. Rabinowitsch, Trans. Brit. Cong. on Tuberculosis, 1901. Vol. III., pages 508-9.

(4) The Liverpool Clauses are given in extenso in the Appendix to this Report. P. 51.

(5) The Sanitary Committee of Newcastle-upon-Tyne are of opinion that the word "advanced" should be omitted from the list of powers to be sought for the city.

3.—With or without suspicion of any milk or milk-product having caused or being likely to cause infectious disease, every sanitary authority should have full power:—(*a*) To inspect the cowsheds and dairy premises of any farm or dairy supplying the district of such authority with milk or a milk-product, and prevent the sale of such milk or its product in their district unless and until they are satisfied as to the sanitary condition and regulation of the cowshed and dairy premises generally in which such milk is produced; (*b*) To inspect, examine, and apply the tuberculin test to any cow; (*c*) To collect at the place of production or elsewhere such samples as they may require of the milk of any cow, the yield of which is intended for sale within the district of such authority: dairymen should be required to render assistance, and any person obstructing should be liable to penalty; (*d*) To prevent under penalty the sale of the milk of any cow re-acting to the tuberculin test, or found to be effected with any form of tuberculosis whatsoever, or any other disease of the udder; (*e*) To brand and cause to be destroyed any dairy cow re-acting to the tuberculin test; the State to compensate the owner in the event of his compliance with the requirements being approved by the sanitary authority; (*f*) To require under penalty that a cow shall not merely be brought into any sanitary district or allowed to remain therein for the production of milk for sale unless and until such cow has been recently, and within a specified time, officially tested with tuberculin and failed to re-act thereto.

4.—The limitation of the prohibition of the use of milk or milk-products of tuberculous cows to such cows only as have disease of the udder should be abandoned as mischievous.

5.—It should be the duty of every sanitary authority (medical officer of health) of a district in which milk sent there for sale from an outlying district is found to be tuberculous, without delay to report the fact to the sanitary authority (medical officer of health) of such outlying district, or the county council in which such district is situated. On receipt of such information by the sanitary authority (medical officer of health) of such outlying district it shall be their (his) duty without delay to cause the tuberculin test to be applied to each cow of the dairy at which such tuberculous milk was produced, and to cause all such steps to be taken as are indicated in the preceding par. 13, sections (d) and (e). Until the completion of such testing, they (he) should prevent the sale of any milk from the dairy in question, and should without delay inform the sanitary authority of every district ordinarily supplied with such milk, that they have (he has) done so. It should be the duty of the county council to see to the carrying out of all of the foregoing requirements, and any farmer, dairyman, etc., who, after prohibition as above indicated, sends milk or its products to any district for sale, should be liable to penalty.

Every sanitary authority should be empowered and required to license for a stated period every dairy and cowshed in their district or in any outlying district in which milk is produced and sent to their district for sale; and to require as one of the conditions of every such license or its renewal that all cows of such dairy, including new additions, be proved by official veterinary certificate, after application of the tuberculin test, to be free from tuberculosis before their milk shall be offered for sale. Any unlicensed milk dealer selling or offering milk for sale should be liable to penalty.

All sanitary authorities should be encouraged to promote, by means of lectures and addresses, the education of the inhabitants of their respective districts as to the nature and causes of tuberculosis, the measures for its prevention, and the duty of private persons and the public generally in respect thereto. The sanitary authorities of Great Britain should unite to establish a Board of Representatives as a supreme national health authority, to deal with tuberculosis and other national disease, physical degeneration, and the various matters relating to public health.

A special Council of Representatives should be appointed to consider and report on the foregoing recommendations, and the action desirable to give effect thereto.

As all sanitary authorities are equally interested in this great question, they are earnestly requested to consider and as far as possible to co-operate in carrying out the foregoing proposals.

OPERATING THEATRES.

ST. PETER'S HOSPITAL.

Partial Excision of the Bladder for Malignant Growth.—Mr. Swinford Edwards operated on a man, æt. 54 (who looked his age), who had presented himself with the following history: Two years ago he had an attack of hæmaturia which lasted two days; he had no further symptoms until April of this year, when on getting up in the morning he passed a large amount of blood and many clots. Since then he had been troubled with increased frequency of micturition (12 by day, 4 by night), and with difficulty in passing water. On admission, and up to the present time, there was always a little blood at the end of micturition. He has not complained of much pain, though there was sometimes slight pain during micturition. He did not think he was losing flesh. Cystoscopy had been performed in the out-patient department by Mr. Pardoe, when a typical epithelioma of the bladder was seen occupying apparently an area of a two-florin piece. It was situated on the anterior wall, and did not seem to involve the vesical orifice of the urethra. Urinary analysis was as follows: Cloudy; light colour; slight reddish deposit; acid; specific gravity, 1013; some albumen; no sugar; urea 1.2 per cent.; microscopical examination showed crystals of urates; there were no enlarged glands to be felt either in the groin or abdomen. The patient having been anæsthetised, supra-pubic cystotomy was performed. It was found that the incision into the bladder went right through the growth. On inserting a finger into the viscus, the extent of the epithelioma could be made out by palpation between the finger and thumb. It was found to have an area of about three inches square, and to be confined to the anterior wall and fundus of the bladder, not extending to the lateral walls. Upwards, it did not go as far as the peritoneal reflection, though there were inflammatory adhesions between the peritoneum and bladder-wall, rendering stripping very difficult. The growth itself, Mr. Edwards said, promised to remove easily. In stripping the peritoneum, the membrane was torn and was stitched up at once with a silk suture. The incision in the bladder wall was then continued upwards until clear of the growth, which last was next gradually excised by means of a pair of scissors, one blade of which was inserted into the bladder through the primary incision. The bladder wall was cut through well clear of the growth (about three-quarters of an inch) on the right side, the cut edge being clamped by a succession of artery forceps, this being repeated on the left side and in this way the growth was completely removed. There was not much bleeding, only a few vessels having to be tied with catgut ligatures The cut edges were brought into apposition before the forceps were removed, and stitched together with stout catgut which did not penetrate the mucous membrane. An aperture was left at the anterior part just big enough to admit a full-sized tube, and the skin incision was closed in the ordinary way, a smaller tube being inserted as far as the bladder-wall. The cuts necessary to remove the portions of bladder extended to within an inch and a half of the vesical orifice of the urethra. Mr. Edwards pointed out that the naked eye appearance of the growth was that of a typical epithelioma. It was a hard nodular ulcerated mass with infiltrated edges, but the extent of growth in the bladder wall did not seem to be much greater than the area of ulceration. No evidences of lymphatic infection were found during the operation. Mr. Edwards remarked that this operation was a very rare one on account of the inaccessibility generally of malignant growths of the bladder. It would be found, he said, that in the vast majority of these the disease was situated around one of the three orifices of the bladder, namely, the two ureteric openings and the orifice of the urethra, so that, as a rule, in malignant cases, the fundus of the bladder was chiefly involved. He had only had one previous case in which a small carcinomatous nodule was excised from the anterior wall of the bladder. In the present patient he had found the growth larger than he had anticipated would be the case judging from its cystoscopic appearance. It practically necessitated the removal of the whole anterior bladder-wall from the apex to within an inch and a half of the urethra. With regard to the operation, the patient was placed in the Tredelenberg position, as soon as the bladder contents had been evacuated. The usual supra-pubic incision was made, but in order to give sufficient access to the field of operation, it was found necessary to divide the inner fibres of the recti on each side. He regretted having inadvertently opened the peritoneal cavity whilst stripping the serous membrane off the bladder, but owing to the peritoneum being tightly bound down in the neighbourhood of the tumour, it was unavoidable. However, it was fortunate he at once recognised this *contretemps*, and took care to repair it before incising the bladder. At the end of the operation a small tube was inserted down to, but not into, the bladder. Mr. Edwards said that there were very few cases of excision of portions of the bladder for malignant growth on record, and he believed that recurrence had taken place in a considerable proportion of the small number recorded In the present case, he hoped for a better result, owing to the free removal of bladder-wall with the tumour, and also because of the fact that there was no apparent enlargement of glands or lymphatics.

A month aftert he operation the patient is passing all his urine per urethram, and the supra-pubic wound is firmly closed. The man himself is in a very satisfactory condition.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, Aug. 4th, 1907.

At the German Society for Surgery, Hr. Thorkild Rovsing read a paper on

Total Extirpation of the Urinary Bladder with Bilateral Lumbar Ureteral Openings.

He observed that total extirpation of the bladder was only rarely performed, although it was frequently indicated with propriety, this was on account of its appalling immediate mortality. Of 31 cases operated on 51 died—a mortality of about 50 per cent. (17 males with 11 deaths—64.7 per cent.; 11 females with 4 deaths—36 per cent.). This high mortality could not be dependent on the dangerous nature of the operation itself, as it could be mostly performed without much hæmorrhage, and without any special difficulties, but the difficulty lay rather in treating the severed ureters in such a way that infiltration of urine and infection of the large, deep wound was avoided. Hitherto the ureters had been chiefly treated in three different ways: (1) opening freely into the wound (Bardenheuer, Kuemmell); (2) into the rectum or the sigmoid flexure (Maydl, Tuffier, Modlinsky, Kuemmell, Krause, Hogge, Wilms); (3) in females by implantation into the vagina with subsequent colpocleisis (Pawlick).

By the first method infiltration of urine was of course unavoidable, with the second, opening into the rectum always gave rise to danger of infection. If the sutures cut through, urine mixed with fæces emptied into the wound, and even where the case ran an ideal course the danger of secondary ascending infection was always to be feared. Vaginal implantation involved castration, incontinence generally resulted and there was also a danger of ascending infection. The speaker had therefore hit upon another way, as he came upon a case of bladder tumour where total extirpation seemed the only way of saving the patient. At the one sitting he performed bilateral lumbar ureterostomy. As his success in this as well as in two later cases exceeded his expectations he believed he was justified in describing his method and recommending further trials.

Under æther and in the Trendelenburg position a wide semi-circular incision with the convex part downwards was made just above the symphysis with partial separation of the insertions of the recti muscles, and the bladder was reached. This which was previously filled with a 1 per cent solution of phenosalyl was now opened, separated from its surroundings like a cystic tumour—in males along with the prostate—and finally removed, after the urethra had been drawn out like a pedicle, and cut through between two pairs of clamp forceps. In two cases he succeeded in enucleating extra-peritoneally, in one the peritoneum was attached and infiltrated with carcinoma. Here the whole peritoneal covering was also removed, and after the completion of the extirpation the large peritoneal wound was closed by a running Kuerschner suture. The wound cavity was tamponnaded with gauze moistened with a 1 per cent. solution of silver nitrate. The recti muscles were again attached, the skin wound was sutured with aluminium bronze, up to the middle line where a strip of gauze was left in. The ureters were then sought through small oblique lumbar incisions, freed as far as the ligatures and drawn out completely so that they hung out of the lumbar openings like two earth worms. The lumbar wounds were then at once closed and covered with collodion and lint. The ureters were then placed in a symmetrical position in the trigonum Petiti, conducted into a sterilised glass container after a No. 12 catheter had been introduced into the ureter beyond the abdominal walls. Outside the ureter was drawn through a perforated rubber cap and protected by it. The ureter now healed in and necrosed up to 2-3 cm. and projected above the skin as a small beakshaped urethra when the necrosed part was cut off in about a week. When the lumbar incisions were healed the catheters were removed from the ureters and from then the urine was cared for by dressings. These dressings (made by Svensen and Hagen, Copenhagen) consisted of a wide elastic binder into which two plates of silver were sewn, each provided with an opening into which the flat silver flasks that collected the urine accurately fitted Flattened silver tubes ran from these to which india-rubber tubes were attached which conduct the urine into a urinal hung below the symphysis. On the under surface of the silver capsule is a rubber ring filled with air which is pressed on by the girdle round the loins. The apparatus had proved its usefulness as the patient first operated on had been able to keep dry day and night for a period of eleven months. The speaker demonstrated the apparatus and also the three malignant tumours removed. He also related the cases in detail, and claimed that the operation could be performed without danger of sepsis or of dangerous infiltration of urine.

AUSTRIA.

Vienna, Aug. 4th, 1907.

Experimental Cirrhosis and Tubercle.

Stoerk reported a few experiments he has made with tubercle to the Gesellschaft. He found that all the animals which were infected with tuberculous matter produced changes in the liver resembling cirrhosis. This transition took place irrespective of virulence or nature of the bacilli. The changes usually commence in the remote or finer ramifications of the blood-vessels in fibrous bands that increased in the opposite direction to the blood current, *i.e.*, from the capillaries towards the larger arteries. The specific epithelial tissue is first changed into a cellular tissue that subsequently passes in to a hard fibrous tissue traversed by the gall ducts. He believes that many cases of cirrhosis are due in the first instance to tubercle and not always to external poisons from excess, &c.

Inguinal Glands and Tubercle.

Bartel demonstrated from a few preparations taken from guinea-pigs into which he had injected tubercle. The first example was a right-sided inguinal lymphatic after subcutaneous tuberculous infection by vaccination The gland was seen to be hard and fibrous with a few isolated giant cells. The second animal had large cicatrices in the lung with bronchiectasis. Three and four animals had been fed, one with infected food, the other with pure food, but vaccinated copiously. The former suffered severely from tuberculosis and was treated for the disease while the vaccinated animal suffered very little. From this he reasoned that there was more danger from food than even vaccination, while breathing was inoffensive. Number five animal by vaccination showed a large quantity of eosinophile cells, enclosed in hard centres in the lungs.

Tar and Nephritis.

Swoboda showed a young girl, æt. 4, who had suffered from nephritis, the result of using a tar ointment for a troublesome eczema. This case seems to be one peculiarly averse to the drug as not more than 30 or 40 grammes at the very outside was used in the treatment of the eczema. The ointment used contained 3 per cent. of the tar product. In the ordinary text-books we are taught to apply large quantities of this substance without any qualifying restraint, not less than 5 or 10 per cent. when administered to young children. This is a mistake. Prescribers should be warned of the danger that lurks in the drug when freely used.

Escherich presumed that the active principle, terebene, was copiously absorbed by the open eczematous wound, which speedily produced the toxic effects recorded.

Schessinger thought the disposition of the patient had more to do with the toxic results in these cases as large quantities of the tar products can be used in open wounds without the slightest symptom of any malaise.

Physiological Lines on Nails.

Schick treated the members to an exhaustive history of the lines on the nails of children. Besides the inflammatory paronychia of syphilitic infants there were physiological lines, due probably to gastric or intestinal catarrh; but such transverse lines are also found in perfectly healthy children where no catarrh exists. About the end of the fifth week a wavy transverse line may be observed on the thumb of the infant, but sometimes appearing first on the fingers, with the convex margin towards the point of the digit, from which it recedes about the 90th day. As a rule these lines appear first in the thumb, and pass along to the little finger in regular sequence. This change has been designated a physiological one, but correctly speaking it is just as pathological as the syphilitic marking. It would appear that this so-called physiological marking of the nails is due to the injury done to the organism when it is passing from the intra to the extra-uterine life. This is supported by the fact that the weight of the child falls during the first week with the well-known physiological desquamation.

Hochsinger said he had often observed this phenomenon when looking for the syphilitic marking during the exanthematous period. Schick's physiological marking was quite distinct from the syphilitic in point of time, the latter being always later than the former.

Swoboda had long observed this linear pathological change in scarlet fever, he said, as well as in other severe diseases.

Escherich thought this marking was due to the disturbed balance in the metabolism after birth.

LETTERS TO THE EDITOR.

THE GENERAL PRACTITIONER.

To the Editor of The Medical Press and Circular.

Sir,—At the recent annual meeting of the Parents' Union I was much impressed by some passages in an address by the Hon. E. Lyttleton, Head Master of Eton. He described as really tremendous the fact that the three great altruistic professions, the ministry of the gospel, the medical, and the teaching professions "are all being starved." He declared it as his conviction that this is principally because we are passing through a phase of believing that excitement, and amusement, and comfort are ends of living instead of very dubious concomitants. He said that thousands of men outgrow the belief; but by the time they do, their professional career in life is fixed, and it is not altruistic or social, because another amazing lie has been somehow stamped upon the minds of the youth of to-day, viz., that social service is dull. If I quote the substance of these passages it is not to express agreement with the idea that the medical profession is being "starved" in the sense that Mr. Lyttleton uses the word. Every general practitioner, at any rate, knows that there are more doctors than are called for. What I want to bring forward and emphasise is the fact that no one should take up the calling of medicine unless he has more than the average of capacity for self-sacrifice. He ought to love science, to love his profession, and have an unlimited amount of sympathy with suffering humanity. If he has a keen sense of humour, and an optimistic temperament, the outcome of sound physique and health, so much the better; and if, along with these intrinsic endowments he possesses at the outset so much of the world's goods as puts him beyond the risk of grinding poverty, his life as a doctor in whatever rank he may find himself ought to leave little real cause for complaint. To practise medicine as a trade, as a mere money-making routine employment, must be always more or less degrading; whilst to pursue such a trade with the sole aim of money grabbing, with the aim first of all of getting as much money as possible out of every patient instead of subordinating every thought to consideration of the welfare of the patient, is to demoralise oneself below the level of the lowest trade trickster of the day. An unqualified quack may sometimes plead ignorance, but no such excuse can be urged by an educated professional man. Men who make money in such a way are not to be envied, they themselves probably always come to recognise that peace and happiness are not to be achieved by such methods. Whilst a doctor must be prepared for a hard life there seems no reason why he should not demand from the State the privileges and the protection, which are his just due. To gain these, I agree with your correspondent G. P., he must combine, and with one voice demand and insist upon his rights. The general practitioner at present seems sadly in want of leaders to guide him in this direction.

I am, Sir, yours truly,

August 1st, 1907. G. P. *No.* 2.

To the Editor of The Medical Press and Circular.

Sir,—I am much interested in the correspondence now going on in your esteemed columns with regard to that despised individual, the G.P. The general practitioner doubtless has his misfortunes and makes his mistakes—like a few consultants—but he has, be it remembered, about ten specialties to keep going all at once, which is rather a strain on a "ranker," when the "officer" finds one as much as he can manage. I have had in twenty-four hours to go from a placenta prævia case (with which I was up all night, and saved the mother, but not the child) to an accident in a mine, and deal with five cases of various kinds of fractures and severe wounds; then drive on to a bad prostatic case with retention of urine in an important county gentleman, and from there to consult with a brother practitioner in a doubtful case of small-pox! Thank heaven, I don't have such days every day, but it shows what we G.P.'s may have to do. Happily, I do not know a tubercle bacillus by sight from a cod-fish, and I have, I confess, a bit of Mr. Bernard Shaw's contempt for the opsonic index, and I think most of my assistants soon get that stuff knocked out of their heads when they find themselves with their first shoulder presentation, or strangulated hernia. If our "pastors and masters" would come down to a rough colliery practice for six months, the medical curriculum would soon be chopped up into something very different.

I am, Sir, yours truly,
Collier.

P.S.—I never read The Medical Press and Circular without finding something in my line, though I always skip the opsonic index, and all that.

To the Editor of the Medical Press and Circular.

Sir,—I have been much interested in the two letters published in this week's issue of your paper and am obliged to the writers of both for their kindly references to me. The works which Dr. Edwards alludes to show that he has given much thought to one need that I emphasised, namely, good text books written to supply particular information for the general practitioner, and with his remarks I am in complete sympathy. But the other aspect of the problem that G.P. draws attention to is a not less important one. How are we to overcome the apathy of the general practitioner, so that he may realise more clearly what is required to improve his own position?

My aim has been to point out that it is for the good of the medical profession *as a whole* that the ordinary medical man should be better represented. That there are many aspects of health and disease of which he alone has experience, and that he cannot be expected to make use of his research opportunities till he is better supplied with literature, has greater leisure, and some pecuniary compensation offered to him for labour honestly expended. It is this *whole* outlook I would ask other medical men to bear in mind. There is widespread discontent felt with the unsatisfactory state of general practice. The fault is, as G. P. remarks, largely our own. When the apprenticeship system was abolished the student lost touch with the conditions of ordinary medical experience, and the improvement in the skill of the practitioner himself caused the consultant to cease his, at one time, customary supervisory control. These two developmental factors have almost separated the general practitioner's outlook from the consultant's and the specialist's, and it rests with him to show how a return to medical unity on a higher plane can be brought about.

I would personally welcome any suggestions or criticisms of real or apparent weaknesses in the position here laid down.—I am, Sir, yours truly,
J. Lionel Tayler.

Willesden Green, N. August 2nd, 1907

Mr. A. Pearce Gould, F.R.C.S., has received a donation of one hundred guineas for the Cancer Research Fund of the Middlesex Hospital from Mr. A. J. R. Carlill.

OBITUARY.

JOHN PIRIE, M.A., M.B.Aberd., F.F.P.S.Glasg.

We regret to record the death of Dr. John Pirie, late of Glasgow. Some years ago, Dr. Pirie retired from the practice of his profession in that city, and went to reside at Courthill, Campbeltown, where he passed away on July 24th. Dr. Pirie, who had reached his 81st year, was a native of Ross-shire. He was educated medically at Aberdeen University, where he took the full Arts course, graduating M.A., and afterwards his M.B. degree in 1851. In 1868, he became a Fellow of the Glasgow Faculty of Physicians and Surgeons. His first appointment was as house-surgeon in the Aberdeen Royal Infirmary, and about the year 1852 he went to Campbeltown, where he remained till 1867, when he came to Glasgow, and there the rest of his active life was spent. Dr. Pirie was a fine representative of the physician of the old school, genial, kindly, and generous, with a rich fund of wit and humour. By his professional brethren he was held in the highest respect, he had the confidence, in many instances the warm affection, of his patients, while he had the regard and esteem of all who had the privilege of his acquaintance. From the time he came to Glasgow he took a great interest in the necessitous poor, and, along with Dr. W. L. Reid and a few kindred spirits, he founded the Glasgow Medical Mission, one of the most beneficent of the institutions of the city. He took a warm interest in everything connected with the Highland counties, and he was at different times president of the Kintyre Club, the Ross and Cromarty Society, and the Northern Highland Benevolent Society. He is survived by three sons and one daughter.

SPECIAL ARTICLE.

ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION.

Exeter, July 27th to August 3rd, 1907.

[From Our Special Correspondent].

The Exeter Meeting has proved an unqualified success. Good weather, numerous visitors, unbounded hospitality, well-ordered meetings, interesting sectional discussions, an exceptionally excellent pathological museum, a good trade exhibition, and many attractive entertainments, social gatherings and wisely selected excursions have all united to crown this year's great Conference of Medicos with distinction. To the President and his *confreres* and many friends and helpers, and also to the permanent officials of the Association, congratulations and thanks are due.

Next year's gathering in the smoke-laden city of Sheffield will not easily surpass the success of the quiet and quaint cathedral centre of the West.

The Business of the Association.

The scientific visitor and the mere perfunctory medico know little of the strenuous work of the Council and representatives. Under its new constitution the Association is slowly finding its feet and testing its powers. As yet, however, it can hardly be said that this large and influential body has come into its kingdom. This year, however, good progress has been made. In the near future important advance will be made in several directions. The rapidly progressing new Central Offices in the Strand will prove of much service in aiding the fit and proper evolution of the Society.

Dr. H. Radcliffe Crocker, has tendered his resignation of the important position of treasurer, and Dr. Edwin Rayner, of Stockport, has been elected his successor. Dr. Smith Whitaker, the indefatigable Medical Secretary, is to receive further assistance, so that the work of his department may be more adequately dealt with. The financial position of the Association received much consideration, and steps are to be taken to extend and consolidate this essential factor. Much time was also devoted to the old perplexities and ever recurring puzzles relating to the relationships of patients, practitioners and consultants, hospital abuse, and medico-political procedure and legislative action touching medical practice and the interests of the sick, and the progress of sanitary science.

Official Addresses.

The President's Address on "Science in its Application to National Health" was received with general approval, and was certainly timely in its strong expression of the need for a national awakening to the importance of physical culture and the urgent necessity for a Government inquiry into the widespread scourge of tuberculosis which is working such loss to us as a people.

Dr. W. Hale White's address on "Medicine" was an eloquent plea for accuracy of thought and a worthy sermon on the righteousness of confession of ignorance, limitation of knowledge and the wisdom of recognising an effort-making agnosticism in matters medical.

Mr. Henry T. Butler's address on surgery was an able and impressive oration on the contagiousness of human cancer, in which he presented evidence that auto-inoculation, though rare, did occur, and thus opened a view to the pathology of malignant disease which had far-reaching practical bearings.

Sir John William Moore's popular lecture on "Weather, Climate and Health" was a well-ordered exposition of man's relationship to various natural conditions which exercise profound influence on the maintenance of health and the production of disease.

The Work of the Sections.

The chief work of the meeting was conducted in the Sections, thirteen in number. Most of these were attended by comparatively only a few enthusiasts, but many valuable and interesting discussions took place, and not a few suggestive papers were presented. The present arrangements for the conduct of the work of the sections leave much to be desired and, evidently, if the scientific value of the annual meeting is to be maintained, close attention should be given to this most important matter. As a first step a time-table should be arranged for each section and rigorously adhered to. Communications should, as far as possible, be of the nature of demonstrations, and all papers should be printed in full or in abstract form before presentation. By these and other improvements in selection and procedure the scientific work and service of the sections would be considerably increased and enhanced.

Among the numerous discussions which took place, and papers which were presented, it is, in the limits of space at our disposal, impossible to refer to any in particular. We are, however, arranging to give abstracts of the more important in our pages during the next few weeks.

Entertainments.

Carping critics are wont to sneer at an annual gathering such as this as little more than a proceeding of "picnicking," and for not a few of the visitors this, t must be admitted, is the most manifest feature. But even a general practitioner is worthy of a holiday, and there seems no adequate objection to associating social pleasures with scientific pursuits. Exeter has, at all events, succeeded in accomplishing this pleasing Union. During this week numerous attractive entertainments have taken place. The Mayor and the Sheriff (Dr. Picard) extended a civic welcome to the visitors and received them in the ancient Guildhall. The Mayor and Mayoress (Alderman and Mrs. W. H. Reed) also gave a garden party in the pleasant grounds of Northcoutray. The President and members of the South-Western branch gave an Evening Fete. A particularly attractive garden party was given by the Lord Bishop of Exeter and Mrs. Robertson in the charming garden of the Palace.

Numerous garden parties, receptions, entertainments, were given, and many most enjoyable private luncheons and dinner parties held, and much courtesy and kindness displayed by many in guiding to local features of interest.

During the week a number of excursions were arranged for to some of the many charming places in the neighbourhood.

On Saturday, the closing "off" day, long excursions took place to Plymouth, Falmouth, Endsleigh, Ilfracombe, and Bideford and Clovelly, after which many visitors continued their delights by extending their holiday and touring into Devon and Cornwall.

The Annual Exhibition.

The "Trade Show" is always an interesting and instructive adjunct, and this year it was excellently housed in the convenient and readily accessible Victoria Hall in Queen Street, near to the Central Reception Rooms. The organizers had succeeded in presenting a thoroughly representative and well-arranged display of all varieties of "material" required for hospital equipment and the conduct of the healing art. The exhibition was well patronised and exhibitors appeared satisfied with the interest evinced by the numerous medical visitors, who, on their part, seemed pleased with the courtesy shown to them and the many and excellent arrangements which had been made for their comfort.

Ninety-one different firms had stands, and many were large and elaborate. Old favourites were conspicuous and many familiar faces were to be seen. Surgical appliances and hospital equipments were particularly well represented.

Down Brothers, Ltd., showed new and original designs for operating-tables, and a large selection of surgical instruments and anæsthetic apparatus and medical accessories. **The Holborn Surgical Instrument Company** exhibited various admirable sterilizers and several ward and instrument tables and a large collection of goods of excellent workmanship at remarkably low prices. **Messrs. Arnold and Sons** had a large and inspiring show, including the high pressure steam sterilizers, as suggested by Mr. W. Bruce Clarke. Also a large assortment of modern instruments employed in surgery, gynæcology, and the surgical specialities. **S. Maw, Son, and Sons** displayed representative types of their aseptic furniture, and of their many special surgical instruments and medical sundries. **John Weiss and Son, Ltd.**, had a large collection of ophthalmic instruments and selections of their most recent general instruments. **Thomas Hawksley** had a very attractive stall at which were demonstrated the use of blood pressure apparatus and other physiological instruments employed in clinical investigations. **Mayer and Metzler** were well represented, and exhibited many forms of instruments used in the practice of laryngology, rhinology, and otology, which well demonstrated the favour in which this firm is held for this most important and delicate class of surgical inventions. **The Equipoise Couch Company** gave practical evidence of the serviceability of their ingenious and admirable equipoise beds, lounges, and chairs. By the adoption of this system, patients may be placed in any position without trouble or exertion. This method of construction should have wide application to the needs of patients both in hospital and private practice. **Geo. Gale and Sons** had a good display of their "Lawson Tait" bedsteads, wire mattresses, and well-designed and strongly constructed hospital furniture.

Allen and Hanbury, Ltd., as usual, had a particularly attractive stand, with many new forms of instruments, transfusion apparatus, operating tables, sterilizing apparatus, and such novelties as Stack's portable dressing sterilizer and Dr. F. C. Eve's cerebro-spinal manometer. **The Liverpool Lint Company** and the **Sanitary Wood-Wool Company, Ltd.**, had useful displays of their well-established antiseptic dressings and other preparations. PHILIP HARRIS AND CO., LTD., exhibited several forms of drug, bacteriological and urinary cabinets, and a particularly serviceable and cheap form of surgery couch. REYNOLDS AND BRANSON, LTD., showed ambulance requisites, a new form of apparatus for the administration of oxygen and many ingenious appliances for clinical work. MESSRS. BROWNE AND SAYER displayed their ideal inhaler, and other hospital requisites. THE AJAX SANITARY COMPANY'S exhibit attracted much attention, being a simple and effective device for lavatory basins, sinks and baths, consisting of a sliding valve or shutter which can be made of any shape and of a variety of materials in a recess at the back of the basin, forming a moveable weir, over the top of which the waste water may run away faster than it can flow into the basin. THE MEDICAL SUPPLY ASSOCIATION presented an elaborate display of their hospital furniture, surgical instruments and dressings, anæsthetic apparatus and electrical appliances. THE DOWSING RADIANT HEAT COMPANY demonstrated their now familiar appliances for radiant heat and light treatment. G. H. NEAL showed his well-known "Repello" and other forms of clinical thermometers..

Electro-medical apparatus was well represented and admirable exhibits of thoroughly up-to-date X-ray high-frequency and electro-therapeutic outfits were made by such well-known firms as Messrs. Harry W. Cox, Ltd., W. Watson and Sons, Marconi's Wireless Telegraph Company, Ltd., Alfred E. Dean, the Sanitas Electrical Company, Ltd.

Drugs, of varying therapeutical value and in almost infinite pharmaceutical form, were exhibited by a large number of firms.

THE DENVER CHEMICAL MANUFACTURING CO. made a prominent show of their useful local application *Antiphlogistine.* THE BAYER COMPANY, LTD., reminded us of the value of such well-established agents as asperin, neroni, tannigen, veronal, and somatose. FAIRCHILD BROS. AND FOSTER made a good display of their "Fairchild Products"—peptogenic milk powder, pepsenica, panopepton, trypsin, noladin, &c. PARKES, DAVIS AND CO., as usual, were well to the front, showing elegant preparations used in modern therapy, including adrenalin, eudrenine, formidine, veratrone, and specimens of their admirable "Glaseptic" nebulisers and sprays. MEISTER, LUCIUS AND BRUNING, LTD., exhibited a selection of antitoxins, serums, &c., including the various tuberculin preparations, and a large assortment of their many synthetical preparations. Novocain and the demonstrations of its methods of employment for anæsthesia attracted considerable attention. THE MALTINA MANUFACTURING CO., LTD., made a bold show with their many and varied "Maltine" preparations. OPPENHEIM, SON AND COMPANY, LTD., showed their ingenious and acceptable "aseptules," "coccoids," and other specialities including their well-known vaporiser and aeriser. THE ANGIER CHEMICAL COMPANY, LTD., again reminded us of the benefits of their petroleum emulsion, and their more recently introduced throat tablets. THE CHARLES H. PHILLIPS CHEMICAL COMPANY exhibited their famous antacid "Milk of Magnesia," a preparation we have long approved and recommended.

ARMOUR AND COMPANY, LTD., well known for their reliable preparations of digestive ferments showed samples of their animal products. Stovaine, one of the new local anæsthetics, was shown by LES ETABLISSEMENTS POULEINE FRERES.

EVANS, GADD AND COMPANY, LTD., made an elegant display of their standardised products, including their Liq. Violæ Glucosidi, Tinct. Digitalis, and Liq. Thymo-Antiseptic Co.

THE SANITAS COMPANY, LTD., had a large show of their ever growing "Sanitas" preparations. JEYES' SANITARY COMPOUNDS CO., LTD., also displayed their "Cyllin" preparations. WYLEYS, LTD. exhibited a selection of their Neroin compound, liquors, medicinal syrups and other well-established and much valued preparations. KNOLL AND CO. showed bromural, styptol, santyl, styracol, and diuretin. The MIOL MANUFACTURING CO., LTD. made a particularly attractive show with their new "Miol," a preparation of olive oil and malt, which we have found of much value as a nutrient, particularly for children.

B. KUHN AND COMPANY exhibited the well-known disinfectant, "Chicnosol," papain and the now popular local anæsthetic ethyl chloride. C. J. HEWLETT and SON displayed their elegant pharmaceutical preparations and several useful forms of antiseptics.

Foods and dietetic preparations, both for the healthy and the sick, the infant and the adult, this year, as in former exhibitions, bulked largely, and their representatives showed no lack of enterprise in advocating the merits of their particular products.

THE AYLESBURY DAIRY CO., LTD., exhibited their new preparations, pollyta and humanoid and also showed various preparations of humanised milk, poumiss and keptin.

MELLIN'S dietetic preparations for infants and invalids were much in evidence, including their "Lacto," food biscuits, and chocolate.

NESTLE'S AND ANGLO-SWISS CONDENSED MILK COMPANY displayed specimens of their milk and milk-chocolate preparations. CADBURY BROTHERS, LTD., and J. S. FRY AND SONS, LTD., furnished liberal samples of their world-famed chocolate and cocoa preparations. INTERNATIONAL PLASMON, LTD., furnished evidence of the manifold advantages and varied forms in which Plasmon can be advantageously employed. Horlick's Malted Milk also found a place. "Virol" was prominent, and the LIEBIG EXTRACT OF MALT COMPANY, LTD., had a specially attractive exhibit of Lemco, Oxo, and other meat preparations.

KEEN, ROBINSON AND CO., LTD., presented the far-famed and old-established Robinson's Patent Barley and Patent Groats and Colman's Sinapisms and other mustard preparations.

A new casein preparation was exhibited by the well-known biscuit manufacturers, MESSRS. PEEK, FREAN AND CO., LTD., called "Tilia," in the form of biscuits, which is likely to become very popular in the near future.

CALLARD AND CO. presented their starchless and sugarless preparations which have done so much to simplify and render palatable the dietary of diabetic and other cases. THE MANHU FOOD COMPANY, LTD., also showed their diabetic foods. G. VAN ABBOTT AND SONS exhibited preparations of their Gluten bread and other foods for diabetics and obesity cases.

THEMHARDT'S FOOD COMPANY, LTD., showed their useful soluble food for infants and their palatable and nutritious "Hygienia." Reynolds' Pure Digestive Wheatmeal and Wheatmeal Bread was prominently displayed. VIROGEN, LTD., exhibited their "Virogen" and other foods. BROOMFIELD AND CO. again showed the useful vegetable fat "Albene."

RONUK, LTD., had a stand on which were set out their various wood stains and sanitary polishes.

THE CELLULAR CLOTHING COMPANY, LTD., showed their excellent "Aertax" clothing, which we can thoroughly recommend from personal experience.

Beverages found a prominent place. Such favourite waters as Perrier, Apenta, Apollinaris, Johannis. ALEXANDER RIDDLE AND CO., LTD., and FELTOE AND SMITH, LTD., presented their lime-juice and lemon preparations. CAMWAL, LTD., reminded medical visitors of its numerous aerated mineral waters, which are particularly fine and palatable.

Friedrichshall, the old-fashioned but valuable natural aperient mineral water, made a praiseworthy bid for a renewal of its ancient and well-merited popularity.

INGRAM AND ROYLE, importers of many forms of natural mineral waters, supplied useful information concerning their particular specialities. Several health stations availed themselves of the opportunity of making known their special climatic and other advantages. Buxton furnished information concerning its mineral waters and baths. Harrogate furnished attractive literature concerning its many means of providing all forms of hydro-therapy in its Royal Baths.

The Borough of Royal Leamington Spa also furnished a stall with literature concerning its special climatic advantages and bathing establishment.

Several medical publishers wisely gave opportunities to country and busy practitioners to examine their books. Among those exhibiting were H. K. Lewis, W. B. Saunders Company, Rebman Ltd.

The Pathological Museum.

All concerned in the preparation of this year's pathological collection merit congratulation. The selection and arrangement of preparations were excellent. Unfortunately, the Barnfield Hall, in which the specimens were laid out, was somewhat out of the way and was not visited, we fear, by many except those specially interested. An excellent catalogue made the collection one of the most valuable and instructive features of the meeting. It consisted of 139 pages of descriptive letter-press, giving descriptions of over 900 specimens, photographs, drawings, &c. A particularly praiseworthy feature were the demonstrations given on three mornings by Mr. Ernest N. Shaw, Dr. F. W. Mott, and Dr. W. F. Bashford.

Where almost every exhibit is worthy of thorough study, it is difficult and appears invidious to particularise. Special interest, however, centred about the extensive collection of specimens illustrating diseases of the breast, lent by St Bartholomew's Hospital; preparations illustrating the researches carried out by the Imperial Cancer Research fund under the direction of Dr. Bashford; the diagrams of Professor Ehrlich, illustrating experimental tumour production, and the very extensive collection of specimens illustrating tropical medicine and parasilology.

The preparations of cerebro-spinal meningitis, sent by Professor Muir from Glasgow, were of special interest and value.

Professor Strassmann, of Berlin, furnished a particularly beautiful series of gynæcological preparations, the mounting of which were beyond praise and admirably adapted for teaching purposes.

Among the special exhibits were series of specimens exemplifying lesions of the Brain and Spinal Cord, and the Liver and Gall-bladder. The large collection of X-ray photographs of fractures near joints and dislocations were of great value to surgeons.

Dentists found a special section devoted to preparations illustrating dental pathology, arranged and classified by Mr. W. H. Yeo.

A department which might well be developed to larger dimensions in future was that displaying instruments for pathological investigation. We should like to see every year a complete exhibit of all new instruments for clinical research.

It seems lamentable that a collection so valuable, and entailing the expenditure of so much time and trouble should be available for so short a time, and should be seen and studied by so few.

It is certainly worth considering whether it would not be of greater service to medical science if the annual pathological museum could not be held in London, and allowed to remain open for at least a month.

This year's collection is so excellent that we think it should support the suggestion which we have ventured to make.

REVIEWS OF BOOKS.

JONES' MEDICAL ELECTRICITY. (*a*)

The rapid issue of edition after edition of Lewis Jones' "Medical Electricity" proves that the work is found useful by medical readers. The present edition contains new matter, such as the use of mechanical means for obtaining interrupted currents of measured duration; the introduction of drugs by electrolysis; the treatment of rodent ulcer by zinc ions; the treatment of skin diseases by X-rays, and so on. The mere recapitulation of these additions reminds us of the rapid strides that are being made in electrical therapeutics. Perhaps one of the most interesting things to note in this connection is the number of skin conditions that are invaluable to modern methods. Lupus of the nasal cavity, for instance, may be attacked with a high frequency electrode; warts may be cataphoresed with magnesium sulphate; xanthelasma of the lids speedily cured by electrolysis, while mycosis fungoides often disappear beneath the X-rays. Dr. Lewis Jones' book contains a great amount of material, which is conveyed to the reader in good literary style. A vast deal of accurate and condensed knowledge is contained therein, and we have every confidence in recommending this work. There is an ample X-ray section and many illustrations.

McCONNELL'S PATHOLOGY. (*a*)

This little manual fills a useful position in the literature of the subject. A wide range of knowledge is covered by the author, who presents his information, in some instances, in the shape of a series of short notes, and in others by a fuller description. The matter, so far as we have tested it, is accurate and up-to-date, such as one would expect from a teacher of the author's experience. There are many excellent illustrations and several coloured plates. In this unpretending volume Dr. McConnell has provided the busy practitioner with an excellent condensed reference book on pathology.

THE GEM CUTTER'S CRAFT. (*b*)

This work, from its title, might appear to be of too technical a charater to be interesting to the ordinary reader apart from those actually interested in gems from a business point of view. A careful perusal has, however, convinced us that it will appeal to very many, both at home and abroad, on account of the highly interesting and attractive manner in which the author has handled his subject. Although a master of his craft he has contrived to make a most readable book and one, too, that while not burdened with over-many technical minutiæ seems to contain most of the information that can be required even by those who make the discovery, mining, and preparation of gems their particular business. In his brief preface the author says, "I do not address myself especially to the jeweller, the miner, the collector, the lapidary, or the amateur, but that my book may prove of interest and assistance to some of these I sincerely trust."

There is no doubt whatever that the author's expectation will be fulfilled, and we hope also that the book will find a place in the libraries of many who do not come into the classes he enumerates. The history of certain famous gems and of gems generally is given, and the curious fancies and superstitions of the ancients regarding some of them. The methods employed for their recognition and the details relating to their preparation (cutting, polishing, etc.), are given in detail. The wealth of illustrations and the excellent manner in which they are reproduced add an interest which could hardly have been conveyed by words alone. Although there are so many (almost as many as there are pages in the book) no one of them can be regarded as "padding," and the letterpress and the illustrations separately are each well worth the price charged for the book.

The publishers have done their share well, the print, paper and binding combine to make the work a creditable addition to any library.

(*a*) "Medical Electricity." By H. Lewis Jones, M.A., M.D., In charge of the Electrical Department in St. Bartholomew's Hospital, &c. Fifth Edition. London: H. K. Lewis. 1906.

(*a*) "A Manual of Pathology," By Guthrie McConnell, M.D., Pathologist to the St. Louis Skin and Cancer Hospital, &c., &c. Philadelphia and London: W. B. Saunders and Co. 1906.

(*b*) "The Gem-Cutter's Craft." By Leopold Claremont, Author of "A Tabular Arrangement of the Distinguishing Characteristics and Localities of Precious Stones," in the *Mining Journal*. London George Bell and Sons. 15s. net. 296 pp. 259 illustrations.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT PATHOLOGICAL LITERATURE.

Treatment by Bacterial Inoculation.—Whereas the "boom" in vaccine treatment which followed on the publication of Wright's discoveries some two years ago has undoubtedly died down, and vaccines are not used as widely as they were a year ago, nevertheless signs are not wanting that the vaccine method is taking its legitimate place in treatment, and that physicians and surgeons recognise better than they did the kind of cases to which it is suitable. One need of the present situation is that practical workers should regularly make their results known—whether successful or the reverse, and that thus the profession should be put in the way of estimating the true value of the treatment, and of learning the rules which govern its applicability. A particularly valuable paper in this respect is that of Von Eberts and Hill (*American Journal of the Medical Sciences*, July, 1907). In other respects it will be of use to practical workers in that it furnishes many hints on technique, and on the fallacies which may interfere with accurate opsonic estimation. (1) Full instructions are given as to the preparation, standardisation and dilution of vaccines for inoculation purposes. The authors advise that if the best results are to be obtained, the vaccine should be derived from the actual infecting organism of the individual case. This rule, however, does not always apply. Thus, they hold that in streptococcic infections, the personal vaccine is a necessity, and in acne a personal vaccine gives the best results. On the other hand, in furunculosis and carbuncle heterogenous vaccines are often satisfactory, and in gonococcol and meningococcol infections the authors look for the best results with heterogenous vaccines. In working with tubercle, they are in the habit of using Koch's T. R., carefully diluted, but they have devised a method of preparation of personal tuberculin. (2) They furnish notes of fourteen cases treated—tuberculous ulceration of bladder, lupus, tuberculous arthritis, tuberculous adenitis, furunculosis, carbuncle (*two*), suppurative periostitis, multiple abscess, acne, gonorrhœal polyarthritis, epidemic cerebro-spinal meningitis (*three*). In all the cases except one of meningitis, which ended fatally, there was either a complete cure or a marked improvement. The notes on the cases emphasise the authors' remarks on the respective value of personal and heterogenous vaccines; (3) The authors state their views as to the supposed necessity for constant estimation of the opsonic index during treatment. They say: "While the opsonic index is a most valuable guide in regulating the amount and time of dosage, we are of opinion that excellent results may be obtained, especially in the treatment of localised tuberculous lesions, without the use of the "Immunity Thermometer"; success in the vast majority of cases attending the employment of minute doses at long intervals. Generally speaking, the feelings of the patient are a safe guide." This opinion of experienced workers, borne out as it is by many others, is of the utmost importance. The main objection to the wide adoption of the vaccine treatment up to the present has been the trouble and expense of maintaining the opsonic control which was supposed to be necessary; if this control can be done without, then the greatest obstacle to vaccine treatment vanishes. R.

Bacteriology of Summer Diarrhœa of Infants.—Morgan publishes (*British Medical Journal*, July 6th, 1907) the results of a bacterioscopic examination of a large number of cases of summer diarrhœa of infants. Cultures were made from the fæces, intestines, mesenteric glands, or spleen in each case. In a small proportion of cases the B. Gaertner was found, and in a few others organisms resembling but not identical with the B. Flexner and B. Shiga. The preponderating organism was one which Morgan believes has not been previously described. It was isolated from 28 out of 58 cases of diarrhœa in 1905, and from 15 out of 34 in 1906. In its general characters it closely resembles the bacillus of hog cholera of MacFadyean, but differs from it in its action on litmus milk, in the production of a larger amount of indol, and in its failure to produce acid and gas in maltose and dextrin. It is pathogenic for animals, producing diarrhœa and death in young rabbits, rats, and monkeys when these animals are fed on cultures. The condition produced in monkeys closely resembled infective diarrhœa in children. Morgan concludes that the type of summer diarrhœa observed in this country differs clinically and bacteriologically from the type seen in America. R.

Anti-rabic Treatment at the Pasteur Institute.—Viala publishes (*Annales de l'Institut Pasteur*, June 25th, 1907) a statistical abstract of the cases treated for rabies in 1906 at the Pasteur Institute. During the year 773 persons submitted themselves to the vaccine treatment; two died of hydrophobia. In one of the fatal cases, however, the disease showed itself less than fifteen days after the end of the treatment. Omitting this case, the mortality would be 0.13 per cent. This is the lowest mortality rate in the history of the Institute, the nearest to it being 0.18 in 1902. The number of persons treated is slightly greater than in any year since 1902. The great diminution from the years earlier than that is due to the establishment of several other anti-rabic institutes in the provinces of France. At present, there are no less than five, situated respectively at Marseilles, Lille, Montpellier, Lyons, and Bordeaux. Of the persons treated at the Pasteur Institute last year, 22 came from Holland, 1 from England, 1 from Russia, and 1 from Greece, the rest being French. In the two cases which ended fatally, the patient was bitten in the face. R.

Pathology of Beri-beri.—Hewlett and De Korté publish (*British Medical Journal*, July 27th, 1907) some observations on men and monkeys which justify a suggestion as to the causation of beri-beri. They obtained several monkeys suffering from a disease closely resembling beri-beri; the animals were very ill, most of them having œdema of the face and genitals; the urine never contained albumin, and the knee-jerks were either increased, diminished or absent. They all died, and the only constant lesion found was congestion of the kidney, accompanied by cloudy swelling, and in scattered areas hæmorrhages into the convoluted tubes. Hyaline casts were constantly found in the urine, which also in some cases contained highly refractile cells of an unknown nature (? protozoa). Attempts to infect healthy monkeys from the sick were not very successful, but in two animals the eyelids became puffy, and the knee-jerks exaggerated. The authors next fed monkeys on urine from human beri-beri patients, a somewhat similar form of illness being produced. The urine of patients suffering from beri-beri was carefully examined. Granular and hyaline casts were present in abundance. In addition, three peculiar forms of body were seen: (1) Small spherical refractile, bodies 2 to 3 m. in diameter, apparently possessing a thick capsule and hyaline contents. They did not give the reactions for fat; (2) large, globular cells, 20 m. in diameter, containing a cytoplasm studded with very refractile granules, and with a single nucleus; (3) large cells, 30 m. in diameter, enclosed in thick capsules, with a finely granular oval nucleus with rounded nucleoseus. These bodies the authors regard as possibly protogoa. Finally, the kidneys of subjects dead of beri-beri were examined; the lesions found were similar to those present in the monkeys' kidneys described, but more intense in degree. As a working hypothesis, the authors suggest that beri-beri is a protogoan infection, that the infective agent is eliminated in the urine, and that the urine is the source of infection. R.

Preparation of Homologous Tubercle Vaccine.—Allen describes (*Journal of the American Medical Association*, July 20th, 1907) a method of preparing personal or homologous vaccine from tubercular sputum. (1) Fresh sputum was carefully washed in six changes of normal salt solution. (2) The sputum was thoroughly beaten up with an ordinary egg-whisk for ten to fifteen minutes. (3) The foam was collected and liquefied by placing it under an exhaust pump. This was found to be the best means of obtaining bacteria free from pus cells (4) The resulting emulsion was concentrated by centrifuging. (5) The fluid was standardised by a modification of Wright's method for other bacteria. The modification consisted in counting the red blood corpuscles in a given number of marked squares before staining, then staining, and counting the tubercle bacilli in the same squares. (6) The preparation was sterilised by heating on two successive days for two hours at 60 deg. C., and an antiseptic added. (7) That the fluid might possess the various toxins and ferments which would be destroyed by heat, a portion of the emulsion before sterilisation was passed through a Beakefeld filter. This filtrate, which was difficult to standardise, was added to the vaccine before injection, or injected separately at the same time. The obvious objection to this elaborate method is that equally good results could be got by making cultures from the sputum, and making emulsions therefrom in the ordinary way. Allen argues, but is hardly convincing, that bacteria grown in culture should differ in their biological effects from bacteria direct from the lung. The author recalls the interesting historical fact that "in 1638, an English professor, Dr. Robert Fludd, advised sputum injections as a cure for phthisis." R.

Histogenesis of Cancer.—Oertel (*New York Medical Journal*, July 6, 1907) describes the changes in a case of cancer of the liver in which he believes he was able to trace the metamorphosis of liver cells into cancer cells. He noticed these stages: (1) The liver cell has lost much of its protoplasm by granular degeneration. The nucleus has lost most of its chromatin, and its nucleolus has disappeared. (2) Regeneration is beginning. The nucleus is enlarged, showing more chromatin granules, and a faint nucleolus. (3) The chromatin granules have coalesced, and the nucleolus is distinct. At the same time there is an accumulation of protoplasm around the nucleus. The metamorphosis is now complete, a cancer cell having been produced. These cells still maintain their lobular arrangement, but when they reproduce they break away from this, and the typical cancer growth is formed. R.

MEDICAL NEWS IN BRIEF.

The Metropolitan Hospital.

AT a meeting of the Metropolitan Hospital Fund, held on Thursday last at the Mansion House, it was reported that the executors of the late Mr. George Herring would pay to the treasurer of the fund £30,000 on account of the legacy bequeathed to the Hospital Sunday Fund, and it was decided that this should be included in the total amount of the fund which would thus amount to £74,165. The distribution committee recommended that disbursements of £68,134 3s. 4d., to 159 hospitals and institutions, 7 dispensaries and 27 nursing associations, and this was ordered. After considerable discussion, in the course of which it was stated that over 1,000 beds in the hospitals were at present unoccupied, and that 62 hospitals in London owed £150,000 to their tradesmen and bankers for current accounts, it was resolved, "That any hospital or institution at present receiving a grant from this fund be invited to consult the council of this fund before incurring further expense in providing additional accommodation for patients."

Tragic Death of a Medical Man.

WE regret to state that Dr. Rynne, of Cheltenham, was found dead on July 20th, at his house. He was about as usual on the previous day, and attended his patients. He rose at the usual hour in the morning, and, according to custom, went to the bath-room. As unusual delay occurred in his making his appearance, the bath-room was entered, and Dr. Rynne was found dead near the bath. He was about 38 years of age, and leaves a widow and three children.

At deceased's residence, on July 22nd, the Divisional Coroner conducted the official inquiry. The Coroner said that the facts were "very simple and very sad," and he was sure would elicit the sympathy of the jury with the widow and relatives of deceased. Mary Rynne, widow of deceased, stated that her husband enjoyed fairly good health. About five years ago he had something in the nature of a fit. On Friday last, he was about attending to his practice as usual. He retired to bed that night with witness about 12.30. Awaking in the morning, witness missed him from her side. On inquiries being made, he was found by witness's brother, Mr. O'Mara, inside the lavatory. The door was locked on the inside, and had to be forced open.—Stephen O'Mara, brother-in-law of deceased, said he arrived at Osborne Villas on a visit on Friday night. Deceased was then in good health and spirits. Witness corroborated the wife's testimony, adding that deceased was lying on the floor, attired in pyjamas and slippers. Witness raised him, and he seemed then to be dead. John Francis Johns, M.D., practising in Cheltenham, who knew deceased personally, gave the result of a post-mortem examination made by him, which showed that deceased had suffered from fatty degeneration of the heart. Death was due to syncope.—The jury returned a verdict accordingly.

The Royal Army Medical College.

THE Royal Army Medical Corps Staff have taken possession of the fine new Medical College, with façades to the river, next to the Tate Art Gallery, and Museum in Atterbury Street, erected by the Government at a cost of £80,000. The lower course of the college is built of grey granite, and the upper stories of brick, with stone dressing. The Grosvenor Road frontage is very imposing, the roof being supported by Ionic columns, resting on a granite portico base, over which is the Royal monogram. There are two blocks, one residential, to accommodate about eighty students, and the other contains the laboratory and museum. The college is equipped on the latest scientific model, and contains lecture and class-rooms, reading room, billiard-room, and officers' mess and quarters. The building comprises lower and upper ground floors, together with first, second and third floors.

It is expected that the college will become a centre for the study of scientific research and tropical medicine. Students who join the college will be young officers who are already qualified, but they will have to pass an entrance examination. There are two courses, senior and junior, which last respectively six and two months. The senior course will be taken by captains who have returned from their first foreign service, and they will undergo at the cost of the Government a special course of Army training by the professors of the college and certain physicians and surgeons of the London hospitals. Lieut.-Colonel H. E. R. James of the Royal Army Medical Corps, is commandant and director of studies, The professors, all of the Royal Army Medical Corps, are :—Military surgery, Major C. G. Spencer, M.B. ; tropical medicine, Lieutenant Colonel R. J. S. Simpson, M.B. ; hygiene, Lieutenant-Colonel A. M. Davies, A.M. ; assistant professor, Major C. E. P Fowler ; pathology, Lieutenant-Colonel W. B. Leishman, M.B. ; assistant professors, Major W. S. Harrison M.B. and Colonel F. J. Lambkin. The clinical teachers in medicine are Mr. H. M. Murray, M.D., and Mr. B. P. Hawkins, M.D. ; in surgery, Mr. G. H. Makins, C.B., and Mr. H. F. Waterhouse, M.B., together with seven other teachers in special branches. The college will be ready for the formal opening in the autumn, and it is hoped that the King may be pleased to perform the ceremony.

The Midwives Act, 1902.

The Local Government Board has issued to Boards of Guardians a circular directing attention to Section E of the new rules of the Central Midwives' Board recently approved by the Privy Council, the section in question relating to "regulating, supervising, and restricting within due limits the practice of midwives."

PASS LISTS.

University of Aberdeen.

At the graduation ceremonial held July 25th, the folowing degrees were conferred on candidates who had previously passed the examination :—

Degree of Doctor of Medicine (*M.D.*).—William Campbell Anderson, B.Sc., M.B., Ch.B.; Robert Brown, M.B., Ch.B. ; James Clark, M.B., Ch.B. ; Frederick William Ellis, M.B., Ch.B. Maurice Buchan Johnson, M.B., Ch.B. ; Peter Macdonald, M.A., M.B., C.M. ; William Mitchell Smith, M.B., C.M.

Degree of Master of Surgery (*Ch.M.*).—Alexander Mitchell, M.A., M.B., Ch.B.

Degrees (*M.B*) *and* (*Ch.B.*) *New Ordinances* (*with Second Class Honours*).—*Walter J. Dilling, *David Horn, B.A., George H. C. Lumsden, *James M. M'Queen, M.A., B.Sc ; Andrew M'Kay Niven.

Ordinary Degree.—Ernest W. Allaway, John W. Archibald, Thomas P. Clapperton, John Ferries, William I. Gordon, M.A., Alexander Horn, John Elrick Kesson, Benjamin Knowles, James Leask, Margaret C. Macdonald, Dalziel B. M'Grigor, William I. Mackintosh, James M. Mathieson, James A. Milne, Benjamin Mitchell, James Mitchell, John K. O'Neil Murray, Algernon Edgar C. Myers, Patrick Nicol, Arthur Shepherd, *Alexander Stewart, William T. Stewart, John M'Intosh Wilson, M.A.

* Passed Final Examination with Distinction.

The John Murray Medal and Scholarship to the most distinguished Graduate (M.B.) of 1907 was awarded to David Horn, B.A., Queensland.

The Diploma in Public Health was granted to Arthur G. Troup, M.B., Ch.B. (Aberd.).

The Conjoint Board of the Royal Colleges of Physicians and Surgeons of Edinburgh and Faculty of Physicians and Surgeons of Glasgow.

The following candidates passed their respective examinations in July, viz. :—

First Examination (*five years' course*).—Francis William Grant (with distinction); James Grant Morrin ; Morris William Rees (with distinction); Francis Patrick Quirk ; James Douglas Wright ; William Millerick ; John Boyd Michie.

Second Examination (*five years' course*).—Surcudra Kumar Sen (with distinction), Edith Huftton, Robert John Helsby (with distinction), Harold Hope Scott.

Four years' course.—Thomas Mitchell Jamieson.

Third Examination (*five years' course*).—Richard B. M. Sullivan, Osmonde Rusleigh Belcher, Thomas Sholto Douglas, Isaac Flack, Henry Frank Collins, Alexander Baxendale, Robert McConnell Blair.

Final Examination, and Admitted Licentiates of the Co-operating Bodies.—John David Jones, James Finbair Jefferies, John Robert Dunn Holtby (with honours), Hugh Clement de Souza, Walter Riddell, Isaac Flack, George Ernest Nash, Walter Ernest Barrett, Gilbert Elliot Aitken, Robert Kay Nisbet, David Williamson Morison, Cuverji Ruttonji Vevai, Jitendra Nath Rai, Clare Annis Langmaid, Bhairàwnath Donanath Khote, Edwin George Hodgson, Charles Jacobs Tillekeratne.

Army Medical Service.

The following is a list of successful candidates for Commissions in the Royal Army Medical Corps at the recent examination in London for which 59 candidates entered. The names are arranged in the order of merit :—

T. McC. Phillips, B.A., M.B., B.Ch., R.Univ.Irel. ; H. S. Dickson, B.A.Cantab., M.R.C.S.Eng., L.R.C.P. Lond. ; G. F. Dawson, M.A., M.B., B.Ch., Univ. Aberdeen ; H. V. B. Byatt, M.R.C.S.Eng., L.R.C.P. Lond. ; R. E. Todd, M.B., B.S.Lond., M.R.C.S.Eng., L.R.C.P.Lond. ; T. F. Lumb, M.R.C.S.Eng., L.R.C.P. Lond. ; H. Gibson, M.R.C.S.Eng., L.R.C.P.Lond. ; C. P. O'Brien Butler, L.R.C.P.& S.Irel. ; G. Petit, L.R.C.P.& S.Irel. ; J. B. Hanafin, L.R.C.P.& S. Irel. ; J. A. Renshaw, M.R.C.S.Eng., L.R.C.P.Lond. ; R. F. O'T. Dickinson, L.R.C.P.& S.Irel. ; W. R. O'Farrell, L.R.C.P.& S.Irel. ; R. De V. King, M.R.C.S.Eng., L.R.C.P.Lond. ; D. B. McGrigor, M.B., B.Ch., Univ. Aberdeen ; C. T. Conyngham, B.A., M.B., B.Ch., B.A.O., Univ. Dub. ; H. McC. Hanschell, M.R.C.S. Eng., L.R.C.P.Lond. ; J. R. Lloyd, M.R.C.S.Eng., L.R.C.P.Lond. ; H. W. Carson, M.B., B.Ch., B.A.O., R.Univ.Irel. ; R. G. S. Gregg, B.A., M.B., B.Ch., B.A.O., Univ.Dub. ; H. T. Treves, M.R.C.S.Eng., L.R.C.P.Lond. ; F. T. Dowling, M.B., B.Ch., B.A.O., B.A., R.Univ.Irel. ; J. C. L. Hingston, M.R.C.S.Eng., L.R.C.P.Lond. ; F. J. Stuart, K.B., B.Ch., Univ. Aberdeen ; B. A. Odlum, L.R.C.P.& S.Irel. ; W. R. Spong, B.A., M.B., B.Ch., B.A.O., Univ.Dublin ; J. F. Grant, M.B.,. B.Ch., Univ. Aberdeen ; P. H. Hart, B.A., M.B., B.Ch., B.A.O., Univ.Dub. ; A. E. B. Jones, M.D., M.B., B.Ch., Univ.Dublin ; A. Hendry, M.B., B.Ch., Univ. Aberdeen.

Indian Medical Service.

The competitive examination for commissions in the Indian Medical Service was held on July 23rd, 24th, 25th, 26th, and 27th. The subjects of examination were medicine and therapeutics, surgery and eye diseases, applied anatomy and physiology, pathology and bacteriology, midwifery and diseases of women and children, materia medica, pharmacology and toxicology. Thirty-three candidates presented themselves for 14 vacancies. The following is a list of the successful candidates arranged in the order of merit :—Hugh William Acton, L.R.C.P., M.R.C.S. ; Vivian Bartley Green-Armytage, L.R.C.P., M.R.C.S. ; Arthur Norman Dickson, M.B., Cantab., L.R.C.P., M.R.C.S. ; Arthur Norman Dickson, M.B.Cantab., M.R.C.S. ; Arthur Batoum Zorab, M.B., B.S.Lond., L.R.C.P., M.R.C.S. ; Alexander Glover Coullie, M.B., Ch.B., F.R.C.S.Ed. ; Robert Ernest Wright, M.B., B.Ch., B.A.O.Dub. ; William Hunter Riddell, M.B., Ch.B.Ed. ; Alexander James Hutchison Russell, M.A., M.B., B.Ch., St. Andrews ; Dewan Hakumat Rai, M.A., M.B., Ch.B.Ed. ; Francis Shingleton-Smith, B.A., B.C.Cantab. ; L.R.C.P., M.R.C.S. ; Arnold Thomas Densham, B.C.Cantab., L.R.C.P., M.R.C.S. ; Arthur Waltham Howlett, M.B., Ch.B. Vict. ; Frederic Allan Barker, B.A., B.C.Cantab. ; Arnold Newall Thomas, L.R.C.P., M.R.C.S.

Plague has made its appearance at Liverpool. At a meeting of the City Council on July 31st, Dr. Utting, chairman of the Port Sanitary Committee, stated that this week they had one case of plague in hospital, and twenty-four cases of suspected contact. Most of the suspected cases are those of foreign sailors shipped at Indian ports

The late Miss Emily Rebecca Leon has left legacies to the amount of £2,000 to the various medical and homœopathic institutions.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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FOR ONE INSERTION:—Whole Page £5; Half Page, £2 10s.; Quarter Page, £1 5s.; One-eighth, 12s. 6d.

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Small announcements of Practices, Assistancies. Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

URBAN DISTRICT COUNCILLOR.—Inquiries tend to show that our correspondent's statements are not confirmed.

C. O. C. P.—It does not belong to the province of a medical journal to discuss a personal matter of the nature mentioned by our correspondent.

HOUSE PHYSICIAN.—Apply to the Agent-General of Colony named, who will doubtless give every detail required. We have not heard of a vacancy for the post having been declared.

SPES.—Wherever possible a patient requiring the high frequency treatment should always be sent to a medical man who has special knowledge of the subject.

M.R.C.S., L.R.C.P. (Leeds).—Our correspondent is advised to write for a catalogue of the latest works and to ask for a list of those upon the subject named which are being most recommended.

DENS.—Yes, it is a recognised fact that the teeth of girls decay sooner than those of boys. The cause seems to be related to the fact that girls are more precocious than boys, and that, as they attain full development sooner, they begin correspondingly sooner to show signs of retrogression.

DOCTOR OR CABDRIVER.

A medical man in a certain small town was rung up about one o'clock in the morning and asked what he would charge to accompany the caller to a country house some three miles away. "Is it a serious case?" inquired the sleepy doctor. "Very serious." "All right; I'll come. I shall have to charge you a guinea." The doctor got dressed, and, having harnessed his horse, they set off. Arrived at their destination, his companion handed over a guinea, and jumped out of the trap, thanking the doctor very profusely for his service. "But—the patient?" "I'm the patient," cut in the other. "You see, doctor, I arrived by the last train, and the people at the inn would not drive me here under 30s. I thought it too much, so I called on you. You offered to do it for a guinea—so here we are."

DISTOMA.—The method originated, we believe, at the Huddersfield Infirmary, and decalcified or cancellous bone certainly seems very useful in some cases of chronic ulcer. You would probably have to prepare it yourself, or make special arrangements with a firm.

LEX.—We have not made up our minds whether the case calls for comment. Such, of course, could only be adverse, and the facts we have are too meagre to justify us in entering the fray. Could you give us ampler details from the spot? If so, we may be able to take the question up in earnest.

DELEGATE.—We fear you will be much too late, but you might write direct to one of the General Secretaries.

GLASWEGIAN.—We cannot enter into private correspondence in the matter. There is no reason why your letter should not be published, and we should be happy to do so if you wish. We can hardly be expected to advise under the circumstances, though we shall be happy, as we say, to publish your complaint.

W. H. S.—Your letter on "The Collection of Debts owing to Medical Men" is unavoidably held over to our next.

OUR PARIS CORRESPONDENT'S weekly letter was undelivered in time for press, owing to the Bank Holiday. It will appear next week.

Appointments.

DE SOUZA, D. H., M.B., B.S., B.Sc.Lond., Demonstrator in Physiology at the University of Sheffield.

SWANN, W. F. G., B.Sc.Lond., Assistant Lecturer and Demonstrator in Physics at the University of Sheffield.

BOWMAN, G. F., M.B., M.Ch.Vict., Medical Officer of Health by the Limehurst Rural District Council.

GOULD, H. U., M.B., B.S.Cantab., Certifying Surgeon under the Factory and Workshop Act for the Shaftesbury District of the county of Dorset.

HAWKSLEY, W. L., M.B., Ch.B., D.P.H.Liverp., Assistant Medical Officer at the New City Hospital for Infectious Diseases, Fazakerley, Liverpool.

HOLLICK, B. S., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Sturminster Newton District of the county of Dorset.

LEWIS, WILLIAM JAMES, L.R.C.P. and S., L.M.Edin., L.F.P.S.Glasg., Medical Officer of Health by the Pontardawe (Glamorganshire) Rural District Council.

Vacancies.

Royal Victoria Hospital, Bournemouth.—House Surgeon. Salary, £100 per annum, with board, lodging, and laundry. Applications to the Secretary on or before August 14th.

Grimsby and District Hospital.—Resident House Surgeon. Salary, £100 per annum, with board, lodging, and washing. Applications to S. M. Forrester, Secretary, Victoria Chambers, Grimsby.

North Lonsdale Hospital, Barrow-in-Furness.—House Surgeon. Salary, £100 per annum, with board and lodging. Applications to the Secretary, North Lonsdale Hospital, Barrow-in-Furness.

Bailbrook House, Bath.—Medical Superintendent. Salary, £450 per annum, with board for self and wife if married, furnished quarters, laundry, attendance. Applications to Herbert Coates, Secretary, 49 Broad Street, Bristol.

Bridgnorth and South Shropshire Infirmary.—House Surgeon. Salary, £100 per annum, with board and lodgings in the Infirmary. Applications to the Hon. Secretary, the Infirmary, Bridgnorth.

Royal South Hants and Southampton Hospital.—House Physician. Salary, £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher Hall, Secretary.

Brighton, Hove, and Preston Dispensary.—House Surgeon. Salary £160 per annum, with furnished rooms, coals, gas, and attendance. Applications to C. Somers Clarke, Hon. Secretary, 113 Queen's Road, Brighton.

Manchester, Corporation of.—Monsall Fever Hospital.—Fourth Medical Assistant. Salary, £100 per annum, with board, lodgings, and washing. Applications to the Chairman of the Sanitary Committee, Public Health Office, Town Hall, Manchester.

Burgh of Paisley.—Infectious Diseases Hospital.—Assistant Medical Officer. Salary, £100 per annum, with board, washing, and attendance. Applications to Fra Martin, Town Clerk, Municipal Buildings, Paisley.

Egyptian Government.—Kasr El Ainy Hospital.—Resident Medical Officer. Salary, £250 a year, with quarters, servants, washing, coal, and light. Applications to The Director-General, Public Health Department, Cairo.

Egyptian Government.—Ministry of Education.—School of Medicine, Cairo.—Assistant to the Professor of Pathology. Salary, £E.320 per annum. Applications to The Director, Government School of Medicine, Cairo, Egypt.

Northampton, County Borough of.—Medical Officer of Health. Salary, £400 per annum. Applications to Herbert Hankinson, Town Clerk, Guildhall, Northampton.

County Asylum, Mickleover, Derby.—Junior Assistant Medical Officer. Salary, £120 per annum, with furnished apartments, board, washing, and attendance. Applications to Dr. Legge.

Newport and Monmouthshire Hospital—Secretary and Superintendent. Salary, £200 per annum. Applications to the Chairman, Newport and Mon. Hospital, Newport, Mon.

Clifden Union.—Medical Officer. Salary £160, with £10 a year as D.P.H., and Registration and Vaccination Fees. Applications to P. H. Bodkin, acting Clerk of Union. (See Advert.)

Births.

MCNABB.—On July 31st, at Withern, Alford, Lincs., the wife of A. A. J. McNabb, M.B., of a son.

HEY.—On August 1st, at 1 Princess Terrace, Ripon, the wife of Samuel Hey, M.R.C.S., of a daughter.

UNDERHILL.—On August 1st, at Castle View, Newport (I.of W.), the wife of S. O. H. Underhill, M.R.C.S., L.R.C.P., of a son.

Marriages.

HEBB—WOLFGANG.—On August 1st, at St. Mary's Church, Byfleet, John Harry Hebb, B.A., M.B., B.Ch.Oxon., only son of the Rev. H. A. Hebb, M.A., headmaster of the Royal Masonic School, Bushey, Herts, to Ethel Kathleen, youngest daughter of the late Elias Wolfgang, of Liverpool.

HUGHES—RIDDELL.—On July 31st, at St. John's, Meads, Eastbourne, Stanley, younger son of the late John Hughes, Esq., of Tero-Law, to May, elder daughter of the late James Riddell, Esq., of Beckenham, and Badulipar, Assam.

POWELL—SENNETT.—On July 31st, at St. Patrick's Church, Hove, Sussex, Edgar Elkins Powell, Major, R.A.M.C., to Gladys Violet, elder daughter of Lieut.-Colonel and Mrs. C. T. Sennett.

Death.

AUBIN.—On July 27th, at La Motte Street, St. Heliers, Jersey, Thomas John Aubin, M.D., M.R.C.S., in his 70th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, AUG. 14, 1907. No. 7

NOTES AND COMMENTS.

August Congresses.

IN August, it has been said, the middle-aged man's fancy lightly turns to thoughts of congresses, and this year the first half of the month has produced, if not a surfeit, at least a plenitude for the most hardy medical digestion. The British Association and the British Medical Association meetings are annual events, but the holding this year of the International School Hygiene, the Housing, and the Esperanto Congresses in England forms a pleasing method of bringing those important subjects to public notice. Although there is nothing peculiarly medical about Esperanto, there is no doubt that the want of a *lingua franca* for medical men has been badly felt since an intimate knowledge of Latin ceased to be part of the education of members of the learned professions. In the fifteenth, sixteenth, and seventeenth century, before the English had developed a good flexible prose, it was almost possible to write with scientific accuracy in the language, but when the common tongue became capable of expressing definite and exact shades of meaning, writers naturally preferred to use it rather than an alien one. The result, however, was that the British scientists became more and more isolated from their continental brethren, till now, in spite of summaries and extracts of foreign papers in the medical press, the average opinion of continental medical men on subjects of current interest is comparatively little known in this country. Moreover, before conducting any scientific research, it is necessary that a man should be a good linguist, if he is to be furnished with knowledge of all that has been done abroad in the particular line he proposes to pursue, and wishes not to work over ground that has been well trodden already.

Esperanto and the Natural Sciences.

RECOGNISING the enhanced value of a record which appeals to all nations, the Pathological Society recently started appending a brief Latin description of their specimens to the ordinary one in the vernacular, and no doubt research-workers and record-hunters abroad will be much indebted to them for the trouble. Still it stands to reason that however adaptable classical Latin may be for scientific records, and even in this it is greatly inferior to Greek, it is not possible to revivify the language for ordinary purposes of communication, written and spoken, as the educational curriculum and brain of man would not bear it. On the other hand we shall be curious to see whether Esperanto which seems to answer well enough for the jargon of the mart, is sufficiently accurate and flexible for scientific records. We should think it highly probable that it is not, in spite of the illimitable facilities it possesses for coining words, because of the paucity—or rather complete absence—of inflexions it apportions to its nouns and verbs. Certainly Esperanto has caught on as neither Volapuk nor any of the dozen other artificial languages has yet, and if it is capable of bearing all the strain that medicine and the allied sciences can put upon it, the boon to research-workers, and indeed to ordinary practitioners, will be immense.

The British Association and Alcohol.

AN immense amount of interest was taken by the public in the debate on the value of alcohol in the Physiological Section of the British Association Meeting. Considering the importance of the subject from the sociological point of view, and also the amount of attention that has been drawn to the subject in one way and another during the last few months, there is not only no need for surprise that so much interest was exhibited, but considerable cause for thankfulness. It cannot, however, be said that the debate advanced the question very far, nor is it likely to make converts to either side, but at any rate it sets forth, to a certain extent, the general opinion of the profession that alcohol is not nearly so useful a drug as was thought thirty or forty years ago. That perhaps is not much, but it must be remembered that even in the Olympian atmosphere of the British Association it is difficult, if not impossible, for speakers to rid themselves entirely of prepossessions, so that, whereas the temperance advocate is likely to minimise a piece of evidence that tells against him, the moderate drinker will insensibly be biassed the other way. The weight of the speakers on the whole was certainly in favour of alcohol in small quantities not being deleterious; but then it might be asserted that those speakers were themselves wine-drinkers.

Professor Cushing's Views.

PROFESSOR CUSHING, who opened the debate in a long and able speech, probably put the case as fairly and temperately as can be. Taking the question of alcohol as a digestive he showed that although there was slightly more active movement of the digestive organs when pure alcohol was administered in small quantities, and a larger secretion of gastric juice, yet this secretion was poor in ferments, and therefore of less avail for purposes of digestion. On the other hand appetite is a great factor in the regulation of digestion, and therefore in those people who are accustomed to a wine and like drinking it, there may be some increase in digestive power by taking a little. Professor Cushing argued, moreover, that it is an undeniable fact that 95 per cent. of alcohol taken undergoes combustion in the tissues, and is consequently a source of energy. Its action he compared to sugar, showing that the energy produced by its combustion may be used for heat formation and mechanical work, and that it may lead to the deposition of fat and consequent economy of the nitrogen store. Further he said that while it is universally admitted that alcohol in large quantities diminishes the tissue-resistance to disease, it is not shown that small quantities had this effect, for although animals treated with alcohol are more susceptible to pathogenic inoculations after they have been subjected to alcohol than before, it is important to remember that alcohol has a very different effect on animals to that which it has on man, animals being merely narcotised, whilst men are excited. He further described some experiments with type-setters and with students which showed that their respective capacities for quick and accurate work were diminished by alcohol.

Man needs but little. A MORE admirable summing up of the present position of the alcohol question than that given at the end of Professor Cushing's paper it would be difficult to find. He said that alcohol may be of some value in therapeutics as a means of making food more attractive, and thus of improving digestion; that it possesses some good value in itself; that it acts as a cerebral depressant, and may be valuable in disease on account of this quality; that it may aid a failing heart; that small doses exercise no definite poisonous effects on the tissues, but that small repeated doses, though suspect, have not been shown to be deleterious. These conclusions were criticised in one way and another by the various speakers, but we venture to think that they stood it very well. As a working hypothesis they would be difficult to beat, and as such they may remain till fuller knowledge is gained on this vexed question. We stand in about as little danger now of heroic doses of alcohol as of heroic blood-lettings, and probably for the same reason, that they were both overdone.

The King and the School Hygiene Congress. OF the School Hygiene Congress the first thought that occurs is that the Committee were lucky in getting together a Congress at all. From the revelations of Sir Lauder Brunton in his inaugural address, it seems that a fortnight ago the whole thing seemed likely to fizzle out, and it was only through the personal influence of the King that the matter was eventually put through. The King, indeed, is the humanising influence in our Government machinery, which last creaks and rumbles ominously when subjected to any unusual strain. The difficulty which the Board of Education and the Foreign Office manufactured for themselves was not apparent to anybody but the disputants, and if it were not humorous it would be utterly degrading to think that the squabbles of two public offices had to be reconciled by the personal intervention of His Majesty before a useful scientific Congress could be held and the guests invited. Scientific men at least will feel grateful to the King for not allowing a slur to rest on their hospitality, and we trust that the lesson that the incident involves will be taken to heart by the young gentlemen in Whitehall who like to direct the affairs of the nation according to their own ideas of what should and should not be done.

LEADING ARTICLES.

The Cult of the Child.

ONE of the more important signs of the times is the increasing care we are paying to our offspring. Fortunately our awakened interest is not fated to assume the attitude of simple curiosity that is sterile of results, for the whole range of achievement of modern medical hygiene is at hand, to say nothing of its complicated and extensive machinery. Nor can it be said that we are dealing with matters that have not come within the purview of modern science, for the study of the environment and conditions of childhood has become an exact and comprehensive speciality. No better proof of the latter statement could be wished for than the International Congress of School Hygiene which has recently concluded the labours of a great meeting in London. The number and variety of the communications and discussions advanced by the members of that body emphasises in no small degree the far-reaching relations of the particular condition of environment dealt with under the title of school hygiene. One of the most interesting considerations, however, is the fact that the subject is engaging the earnest attention of all civilised nations; in short, wherever the need of State education of the child has been recognised, there the necessity of the scientific care of his school environment is becoming accepted as an inevitable corollary. The position thus entailed is so strictly logical that it is somewhat of a wonder that it was not established long ago. But after all the science of public health is itself a comparatively recent creation and its application, notably in the case of tuberculosis, still halting and unsatisfactory. Yet who can doubt that the millenium of early sanitary pioneers like Parr and Simon will one day come upon the nation? In a certain sense the deliberations of the International School Congress may be regarded as the natural outcome of their labours. At any rate, it is certain that civilised society will in future take steps to safeguard the health of its school children. It is obviously of little use to bewail the physical degeneracy of our race if we neglect its nurture during the crucial years of infancy and childhood. There are, of course, many difficulties in the way of securing an effectual control of the health of scholars, both as regards parents and as regards local administrative bodies. There is no doubt that the legislature must sooner or later enforce proper standards of sanitary construction in all cases. More delicate ground is touched in the attempt to apply individually a system of detailed medical inspection, which is an absolutely essential condition of the hygienic control of school life. Without the consent of parents, and possibly also of scholars themselves, it would probably be illegal to conduct an ordinary physical examination, including such necessary steps as an enquiry into the state of the scalp and the throat. Difficulties of this kind, however, are of a somewhat theoretical nature, and are hardly likely to present any serious obstacle in actual practice. So far as the medical profession is concerned there are several aspects of the question that deserve careful attention, especially now that universal medical inspection of schools is certain to become an established fact in the near future. First of all there is the relation of the school medical inspector to the general practitioner, obviously a matter of importance. At first sight it would seem advisable, wherever possible, to insist that the inspector shall be a special officer not engaged in private practice, and therefore not likely to come into collision with outside general practitioners. Then there is the question of fees payable for outside medical men by education authorities. At present there is a reprehensible tendency for the State to demand the services of medical men without remuneration as in the case of birth and death certificates. The school authorities wisely determine a child suffering from ringworm shall not attend school. They demand a certificate which is, as a rule, obtained free from a hospital or from a general practitioner. In any case the school committee pays nothing for the information, and in other cases the general practitioner is expected to supply his professional information gratis. A matter of this kind should be most carefully safeguarded by medical members of Parliament, for as a rule the legislature year by year demands fresh services of medical men, but neglects to make provision for their adequate remuneration. In this problem of school hygiene the medical profession is the primary source of inspiration, and as a matter of common fairness its material interests should be placed on a basis of adequate pecuniary recognition.

CURRENT TOPICS.

The British Medical Association and The General Medical Council.

In commenting recently on the relations existing between the British Medical Association and the General Medical Council, we expressed the hope that the Association would soon come to a definite decision on the question of its position as prosecutor before the General Medical Council. In this we have not been disappointed, for by an almost unanimous vote, the Representative Meeting at Exeter last week expressed its approval of the action of the Ethical Committee in appearing as prosecutor in a recent case. That the members feel very strongly in the matter is evident, not merely from the vote, but still more from the fact that the vote was given in the face of the opinion of counsel that the application of the funds of the Association in this direction is illegal! If any member objects to the funds being spent in this way, it will be necessary for him to proceed in the High Courts for an injunction to restrain the Association—a risk which apparently the Representative Meeting was willing to run. Apart altogether from the question of the wisdom of the Association taking on these extra functions, there can be no doubt but that it is unwise to proceed by illegal means to arrive even at an admirable end.

Finger-Licking by Clerks.

In these latterday scientific times many of our cherished habits and customs have gone by the board. Beyond a doubt a host of others will follow before the man in the street may hope to approach the standard fixed by men of science. Of all the filthy and disgusting habits there can be none less capable of defence than that of licking the finger which is used for turning over leaves, for counting money and so on. The tram conductor offends in this way that he may get a quicker and a lighter grip of the ticket that he hands, laden with countless bacteria, to his luckless passenger. So too, among other public servants, the hurried railway clerk, to whom fractions of seconds are of value, does the same thing with tickets and with money, in which latter case the customer pockets myriads of microbes along with his change. Clearly if the finger-licker is suffering from tuberculosis, diphtheria or any of the hundred-and-one microbial maladies that may affect the mouth, he distributes to the public the germ of disease on the surface of tickets and of coins. Therefore he should not lick his finger. How is he to be prevented? Shall the man in the street read him lectures, or educate him at an early age in schools, or make it a punishable offence? Somehow he must be convinced of the horror of his ways, and persuaded that in future he must not lick his fingers.

Mr. Carnegie's Gift.

Mr. Carnegie, among his many princely benefactions, has never given anything, at any rate on a large scale, to the London hospitals, although it is well known that they all need extra support badly. The reason has always been supposed to be that Mr. Carnegie objected to the way they are managed; that he thought, in fact, they are not managed on sound business principles. His splendid gift of £100,000 to the King Edward VII. Fund last week came to Londoners as a pleasant surprise, but though Mr. Carnegie did not accompany the money with a stipulation, he sent with it a heart-felt wish that the committee would get to work on reform as soon as possible. While everybody admires.

the public spirit and self-sacrifice displayed by the many high-minded gentlemen who give up their time and energies to hospital work, it must be admitted that they have allowed conditions to master them, and that in the stress of competition for funds and patients they have been driven to use methods which in the course of private business they would condemn. Notwithstanding the fact that there are at the moment some one thousand beds unoccupied at London hospitals, and debts to the amount of £150,000 to bankers and tradesmen on current account, appeals for building funds still appear over and over again. As a matter of fact committees have found that the safest "draw" for subscriptions is to announce a building scheme or special appeal, and the temptation to resort to this measure of despair increases with its success. When the buildings are finished all the money is used up, and as likely as not either the beds are not occupied or the hospital has to sell stock to keep them open. We hope with Mr. Carnegie that more reasonable methods will take the place of these gambling expedients.

Performing Lions and their Performances.

JUDGED from the point of view of the circus contents bill, the British public must retain a fair share of primæval savagery. Otherwise, the enterprising showman, who reads his audience like an open book, would not take so much pains to provide them with a hundred and one entertainments in which human life hangs, as it were, on the hazard of a thread. Every now and then some acrobat breaks his neck, or some lion-tamer is torn to pieces before a shrieking mob of sightseers. Yet humane society which passes bills to prevent cruelty to animals, and holds the scientific vivisectionist up to public pillory, permits these wanton side shows, with their gruesome work, to go on in the interests of the showman's till. Only the other day at Gloucester an attendant was killed by a lioness belonging to a travelling lion-tamer, who declared that the beast had always been regarded as harmless and docile. That fact merely proves that it is impossible to say when the lion has been effectually "tamed." A terrible death of the kind mentioned furnishes a grim satire on the civilisation and humanity of to-day, which appeals to great Heaven anent atrocities in Macedonia or the Congo State, and allows fellow countrymen and countrywomen to be mauled to death before their eyes, not only without a protest but even paying for the privilege of witnessing the unholy and degrading performance, which attracts many by its proffered butchery.

Mr. John Burns and Gratuitous Medical Service.

WHEN Parliament passes a measure that necessitates legal work, the lawyers in the House take care that provision is made for proper payment for such service. When new medical services are demanded, however, it is only rarely that the question of remuneration is mentioned. As a rule, the politicians concerned adopt the attitude of the outside public, namely, that they shall get as much gratuitous work as possible out of the medical profession. A good instance of this kind is the Bill for the Notification of Births recently brought before the House as a private Bill, and since adopted by Mr. Burns on behalf of the Government. It provides that a medical man must notify a birth within 36 hours, but gives him no fee for furnishing the information and signing the necessary document. Were a corresponding duty to be thrust upon a solicitor he would secure six and eightpence for every step in connection with the formality. Of all men we should imagine Mr. John Burns would be the first to recognise that the labourer is worthy of his hire. Now that the injustice of the proposal to saddle an honourable but by no means rich profession with fresh unpaid responsibilities has been pointed out to the right honourable gentleman, he surely will take steps to remove an obvious flaw from an otherwise most desirable measure. If the income of the medical practitioner is not reinforced from State sources, directly or indirectly, there seems to be some danger of his being forced ultimately out of the field, so keen is the competition with hospitals and with numerous forms of unqualified practice.

Japan leads the way in School Inspection.

THE appearance of Japan upon the stage of the world's politics offers much food for reflection. Perhaps the most salient feature of that remarkable people is their firm grasp of the practical aspects of modern scientific principles. By seizing upon advanced methods of tactics, weapons, transport, and medical service, the Japanese have crushed the power of probably the most potentially powerful country on the globe. But it is not only in warfare that Japan leads the way. In the matter of education she is an easy first, so far as medical inspection is concerned, and, in point of fact, has left the United Kingdom lagging hopelessly in the rear of the international struggle. Japan has recognised the fundamental truth that the aim of all true education should be to produce that type of citizen who shall be the fittest in all respects, whether mentally, bodily, or morally. She has not entrusted so vital a matter to the selfish arbitration of party politics, but has gone straight down to the root of the thing, and straightway appointed something like 9,000 medical school inspectors. Here, in Great Britain we have less than a hundred such officers appointed by local authorities who have availed themselves of their power in that direction, and even then their chief care is for the buildings rather than for the scholars. The first serious attempt to apply the system of medical school inspection universally was made in Mr. Birrell's Education Bill thrown out last year. It is to be hoped, however, that before long the Statute Book will be extended by a provision of the kind, which will to some extent enable England to remove the defect which now so seriously handicaps her in the development and progress of her race.

Lead as an Abortifacient.

AN inquest last week in the neighbourhood of Sheffield has called attention to the lamentable practice of taking lead pills to procure abortion. The deceased was a married woman, who died in hospital as the result of blood poisoning following abortion. While under treatment she confessed to the surgeon that she had taken diachylon from a plaster mixed with bread crumbs. Careful inquiry failed to reveal where the lead was obtained, and the jury returned a verdict that death was probably caused by the taking of diachylon pills to procure abortion. The Coroner spoke in the strongest possible terms of this terrible evil which of late years had sprung up among women. In certain districts, of which Sheffield appears to be one, the practice has become notoriously common. In these days of social legislation it would be well for the Government to revise the Sale of Poisons Acts, especially with regard to the sale of diachylon. Another point that at the same time might be alluded to with advantage is the resolution to make it compulsory to keep all liquid poisons in distinctively shaped bottles. Only a few days ago a lady was poisoned by mistake with carbolic acid which a servant took from a bottle precisely resembling the regular physic bottle by her side.

Medical Referees and Women.

In the report of a recent meeting of the Bradford Trades Council, objection was taken by the Executive to the appointment of a particular medical referee for their district on the ground that he was medical officer to a railway company on whose behalf he would also have to act in cases of accident as employers' medical adviser. Mr. F. W. Jowett, M.P., said he had spoken to the Home Secretary personally about the matter, and in the course of his interview Mr. Gladstone told him that he was anxious to know if women workers were desirous of having medical referees of their own sex to examine them, and Mr. Jowett proposed taking steps to find out. We venture to express our opinion that this suggestion raises the sex question in medicine in a most unfortunate form, and one which we fancy the women members of the profession will resent as much as men. The only possible reason why women workers should be examined by special women referees is that there would be some unpleasantness or impropriety in their examination by men, a suggestion which we fancy the Home Secretary will see, on reflection, to be offensive to medical men. Women workers in factories are accustomed to statutory examination by the factory surgeon on many occasions, and they come to look on him in the light of a tutelary deity who guards them from any injustice on the part of inconsiderate employers, and that view is exactly what the profession likes them to take. Moreover, it is common knowledge that such women-workers in their confinements and in times of sickness seek the aid of masculine medicals, who become, in most cases, their honoured friends. Women doctors, for their part, are generally anxious, as we have always gathered, that they should be treated on their professional merits, and be looked upon, from the point of view of society, as medical practitioners, simply and solely, without reference to sex. It is, therefore, quite gratuitous that the latter question should be raised in regard to the appointment of medical referees, and we think Mr. Gladstone will be well advised if he makes his appointments in the present by professional suitability, as recommended by the Departmental Committee. It is much to be hoped that the Government and other official bodies will steadily discountenance the importation of the element into medical appointments in which it does not naturally exist.

PERSONAL.

A Banquet was recently held at Porth in honour of Dr. Ivor H. Davies, who has left the district to take up his residence at Llantrisant. The occasion was marked by the presentation of a handsome silver service and an address.

Lieut.-Col. A. W. Browne, late R.A.M.C., has been appointed to Militia medical charge at Armagh. Major S. Macdonald, M.B., C.M., from Woolwich, has been appointed to Army Medical Service at Hong Kong.

Mr. Andrew Carnegie has given unconditionally the sum of £100,000 to King Edward's Hospital Fund for London. Mr. Carnegie expresses the desire that it should be used as seems best, "the more strenuously for reform the better."

Sir John Dickson-Poynder opened the International Housing Congress at Caxton Hall, Westminster, on August 5th.

Dr. Hugh MacLean, of Aberdeen, has been awarded a Carnegie Fellowship for his research on "The Carbohydrate Material and Ferments of the Blood."

The executors of the late General Baynes has forwarded a second sum of £10,000 to the King's Hospital Fund for London.

Professor Howard Marsh has been offered, and it is understood, has accepted the Mastership of Downing College, Cambridge, which has been vacated by Dr. Alexander Hill.

The Foundation-stone of the new Out-Patient Department of the Cardiff Infirmary was laid by Sir William T. Lewis on July 30th. Mr. Edmund Owen subsequently addressed the visitors.

Dr. W. Wynn Westcott presided at the annual general meeting of the Medico-Legal Society at the end of last month. Mr. Justice Walker was elected president for the coming session.

We regret to record the death of Dr. W. D. Miller, of Michigan, till last year Professor of Odontology in the University of Berlin. Professor Miller was known throughout the world as an authority on the teeth, and he had been for a long time at the head of the Berlin University Dental Institute. He introduced the game of golf, in which he excelled, into Germany.

About one hundred of the American, Colonial and foreign delegates attending the second International Congress on School Hygiene paid a visit to Oxford on Saturday. Luncheon was partaken of in the hall of Christ Church, at the invitation of Dr. W. Osler, the Regius Professor of Medicine, who presided.

We regret to learn that, whilst cycling down a hill near Colwyn Bay, Dr. Greenhalgh, of Bury, lost control of his machine. He was thrown off, and sustained a broken arm, and an injury to his forehead,

A Clinical Lecture
ON
THE MORE RECENT TREATMENT OF THE INSANE (*a*)

By G. H. SAVAGE, M.D., F.R.C.P.,

Consulting Physician for, and Lecturer on, Mental Diseases, Guy's Hospital; Examiner in Mental Pathology, University of London.

Gentlemen,—I have named my address for this afternoon "The More Recent Treatment of the Insane," because I am always protesting against treating insanity as an entity, as a definite disease. We have to consider the insane person, and the treatment of the insane differs very materially now from that of even a very few years ago. A history of the treatment of the past is almost an essential to an understanding of the stage which we have reached now. By the way, the recovery-rate is not much greater now than it was 100 or 150 years ago. That, of course, one regrets, and hopes for better things. The Biblical treatment of the long past was not unreasonable; the treatment of Saul by David was certainly correct; and as to the treatment of Nebuchadnezzar—turning him out into the country till he recovered—that was a case of non-restraint treatment effecting a cure. We have only come back to that even now. The next idea was that all insanity was associated with theological error, that, in fact, every insane person was afflicted by some spirit, generally a spirit of evil; but, sometimes, a prophetic spirit. Therefore the only way was to eject the spirit. Consequently chains, chastenings, and whips were used. Sometimes he had to be cast out by stinks, therefore remedies like asafætida, which is still used in the treatment of neuroses, were used for the ejection of the devil. There is still, in the centre of Europe, a cathedral and a town, and around it some fifteen villages, called Gheel, "The City of the Simple," where for 700 years the people have been treated at the shrine of Dymphna. Here I spent a week of great interest years ago. I suppose I am asked once a week whether there is any objection to a patient being treated by "Christian Science," thus coming back to the old thing. Hypnotism I am constantly being asked about, and I shall refer to that later. As society came more closely together, people said they must be protected against the accidents resulting from the insanity of certain people and, to effect that protection, the insane were shut up. Asylums grew, and are growing still. In the earlier days they were not specialised; all cases of all kinds, whether curable or incurable, were lumped together. Now one of the great developments is the separation of them; so that there are not only idiot asylums, but idiots are being separated. Thus you find schools for feeble-minded and institutions and colonies for the weak-minded, who are not distinctly idiotic. And one of the developments which will have a very great influence in the future is hospitals for the insane. I have said to you before that there are two words which I should like to get rid of from the English language—"asylum" and "lunatic." It will take a hundred years, even after they have been abolished, to do away with the stigma; the old feeling that a person affected in his mind is therefore alien and must be shut off, so that a person suffering in his highest faculties is an outcast. And when one remembers that a very large proportion of these people get well, and a larger proportion than the public believes remain well for the rest of their lives, it is a shame that they should be treated as if they were altogether useless as soon as they have had one attack of mental disorder. In Glasgow—and we must admit that North of the Tweed they are in advance of us in many ways—they have now a Receiving Hospital, so that every person suffering from mental disorder who falls into the hands of the equivalent of the relieving officer or the police is sent to this hospital, not to an infirmary or an asylum straight away, unless he happens to be a typical general paralytic, or to have some incurable disease of that kind. There are two wards in this receiving hospital, and I spent a day there not long ago to see the types of cases, and to see the results. The result is that not more than half these cases go to an asylum at all, but are discharged. Drink is, of course, the cause in many of these cases, but not by any means the majority. I said to the superintendent that I supposed the acute alcoholics came back fairly frequently, but he said "No"—that their experience was that, short of a year, or even more, the treatment of an alcoholic for a month or six weeks in the hospital was as useful, in the long run, as asylum detention for two or three months. In fact, he said that unless an inebriate was going to be secluded for a year or two, the result of hospital treatment in bed, with strict supervision and dieting, and medicine to a certain extent, was as useful as prolonged treatment, and much more useful than simple detention for three or four months.

Another development is hospital asylums, of which type Bethlem is the oldest example. St. Luke's is another old institution. Scattered over the country there are establishments like the Holloway Sanatorium. What salvation is in that word "sanatorium"! People do not mind going to Holloway Sanatorium, but if it were called the Holloway Asylum they would shy at it. In York there is a Retreat, and similar institutions at Exeter, Gloucester, and Manchester; and they are to a great extent self-supporting; some pay for their care, some pay but very little; but those who pay more help to support those who pay very little. At Bethlem Hospital, the majority of patients pay nothing at all; a certain number pay two guineas a week; in some places patients are received for even a guinea a week. There is another development, which I feel particularly interested in, because when I was at Bethlem I revived it, that of voluntary boarders. At that time there was still permission for the Royal

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Delivered at the Polyclinic, Chenies Street, London, February 27th, 1907.

hospitals, such as Bethlem, to receive a certain number of patients suffering from mental disorder, as voluntary boarders. I had difficulties, and I had a struggle. The authorities said: "Well, but this man is of unsound mind; he has got delusions." "Yes." "Will you receive a voluntary boarder who has got delusions?" "Yes." "But he could be certified." "Yes, but that is exactly what I don't want. The man says, 'I am supposed to be of unsound mind. I do not think I am. I am quite willing to come into a hospital where I can be under observation, and where you will see that you are wrong and I am right.'" A person who has had an attack of mental disorder once, or twice, and has recovered, says, "Next time I get like this I shall prefer to return." I remember in the old days a patient driving to Bethlem Hospital and saying, "I want to be taken in; I feel I am going off my head; only if you take me in you will send word to my family where I am." At Bethlem Hospital there are probably 25 voluntary boarders; at Virginia Water there are a large number of voluntary patients, and one hopes it will be still further developed. You can understand that in county asylums it would be rather a dangerous thing to have voluntary boarders. The Commissioners quite properly require that those who wish to become voluntary boarders shall say in writing that they wish voluntarily to so place themselves; and there must be some statement by an outside medical man, preferably a general practitioner, that in his judgment the case is a fit and proper one. Over and over again this sort of thing occurs to me: A man comes and says, "I will kill myself." "Nonsense! You feel you will kill yourself?" "Yes, and I will." "Don't. It will be inconvenient for you, for your friends, and for me, now you have consulted me. I will telephone to see if they will receive you at either of these institutions." Yes, they can receive him, and he goes. I send with him a note that I consider him a fit and proper person to go as a voluntary patient, and he goes. The wave of despair passes; he is treated medically, and is discharged recovered. The more people recognise that hospitals for mental disorder can be used like homes or like hospitals of another type, the more will be removed the current dread of those institutions. It is a great thing to feel that they are going there for treatment, not for detention; the great trouble felt by the insane is that they are no longer free agents.

The next improvement, again along Scotch lines, is boarding-out. They have a patient here and a patient there at small houses, people who have been acutely insane but have recovered up to a certain point. And we must remember that many surgical and medical cases have only partially recovered when they leave the hospital, but they may have at once to perform their social duties. One who has had acute insanity may be left lamed in mind; he may no longer be able to fill the position he did; he is weak-minded, but he may be perfectly harmless; he is the class of man who is a hewer of wood and a drawer of water in asylums. A large amount of work is done in asylums by chronic patients. Some of them are specialists; there was one in Bethlem who would do nothing but polish brass knobs, though he still believed himself to be the Holy Ghost. Boarding such people out enables them to live happier, freer, and less costly lives; and no doubt the practice is extending in England. In 1890, it was decided that there should be no more private asylums' licenses granted; consequently, the hospitals have grown, and are receiving large numbers of patients of a class who used to be sent to private asylums or to the cheaper asylums. Hundreds of people all over the Kingdom are asking to have patients. Nurses leave asylums, marry, and say they have a nice little house and can take a patient. Three thousand doctors have applied to me for patients, therefore there are a large number of patients living scattered about, I presume, and I fear there is great danger of abuse. The abuse which called lunacy legislation into being was largely the fact that, literally, people were living upon lunatics under their care; people farmed them. I am always maintaining that we do not so much want certification of the insane as notification of them. Let there be a notification of insanity when it reaches a certain line, just as there is a notification of fever. If a person is insane, but not dangerous to society, let it be known and the patient kept under some kind of supervision. Otherwise, I feel sure there will be abuse. Certain so-called "colonies" I find very helpful; there are epileptic, feeble-minded, and inebriate colonies. I do not like to give names, but I will describe one. A doctor has a farm of 1,200 acres. On that he has ten or a dozen small villas, bungalows, cottages, and in each of these is a farm bailiff, a cured patient, a City missionary, a cured inebriate, a cured morphinomaniac, or someone else who has experienced mental trouble. In each of these houses are two or three borderland cases, who have fallen in some way, and are out of step with society, yet who are not dangerous or suicidal. These individuals are absorbed into this colony, and they are gradually educated back to self-respect; they are trusted. The doctor himself knows nothing about payment; that is arranged with the head of each house. The results are extraordinarily good. I had a letter from him this week, wishing I could go down and see the batch of discharges which he is sending to Canada, they having been there a couple of years and learnt many occupations, including, of course, agricultural ones. Of course, one has to recognise that there are failures, but who does not fail? Our successes are built up upon our failures. Therefore the future treatment of insane people, especially young growing cases, is to put them in healthy conditions. Insanity is not a disease depending on a micro-organism, though it may in some cases spring from diseased states; but it is a want of relationship of the individual to his surroundings, and if you modify his surroundings you may often get him back to usefulness.

Now as to treatment. It seems to me we are always inclined to sway backwards and forwards. First, every lunatic must be shut up, and now the feeling among certain physicians seems to be that every lunatic ought to be sent travelling; and I have sometimes said that part of the Atlantic must be paved by these people. It is a very dangerous thing to send a person of unsound mind travelling unless you know all about him. Some time ago, I was told a patient was to be sent for a voyage, and I said I was very glad I was not going with him. Next I heard that after being a short time at sea he attempted to drown himself. The consequence was that the rest of the voyage, which was to do him so much good had to be passed in the cabin under the strictest supervision

Doctors have the common failing of recommending that which suits themselves. If a person has an inflamed eye he does not at once go to a picture gallery. He is put into a dark room, and is kept quiet. Melancholia, in many cases, is mental pain; and do you suppose that when the mind is suffering painful impressions it is best to exercise it? It requires rest. One man finds rest at the seashore; another in pottering about a garden or on a farm. One man who had an attack of melancholia which lasted a year, showed me a road he had made entirely, including quarrying the stone. He said, "That was my cure for melancholia." Doctors sometimes say, "Don't you think it will be a good thing to make him buck up?" I think it would be disastrous; but there are some to whom it would be immensely useful. A man makes a fortune before he is middle-aged, and he is induced to retire from business. He has devoted twenty-five years to making money, and thinking of nothing but money, and the making of it. He retires; and he has not got a healthy vice at all. If you cannot get him back to some business, then if you send him for a year or two's travel he may gradually settle down into a different man. Travelling is useful in certain hypochondriacal cases. When insanity depends upon physical disease, treat that disease; do not treat the insanity, but treat the individual. Travelling has its advantages, but it also has grave dangers. I have seen many people made very much worse by travelling, and many cases have ended fatally as a result. Then comes the swing of the pendulum the other way. "You say hospital treatment for the insane is good; very well, give them all 'rest cures.'" If the patient is badly nourished, if his digestion is failing, if he be physically weak, Weir-Mitchell treatment may be of enormous advantage. But if the person be a self-indulgent adolescent, he or she must not be allowed to soak in self-indulgence; it would be the worst thing possible. Brooding leads to hatching, and brooding in bed leads to all sorts of delusions. I have seen a person put to bed slightly depressed, and get up confirmedly deluded. But in some cases it is beneficial, as in the following case which recently came before me. I was asked whether a certain lady would not be benefited by a "rest-cure" in a nursing home. First, one had to decide: Is that person really insane, dangerously, so that it is not justifiable to send her to a nursing home? No. She was hypochondriacal, quarrelsome, and inclined to upset the household generally, wherever she was. She was about 2½ st. below her normal weight. She was put into a nursing home, isolated from her friends. Nurse No. 1 does not get on with her; Nurse No. 2 did very well. There are the surroundings of peace; she is not seen much by a doctor, nurses look after her chiefly, and massage is increased. She puts on 2½ st., and even more, and begins to think she is going to become too fat. But she is inclined to say "I am so happy here that I will stop here." Now comes the time to break down adhesions, and therefore one tells her to go somewhere else. She is sent to the home of a cultured lady who has had experience of such cases, and slowly she gets perfectly well. If she had had her way she would have gone on having "rest cures" for the remainder of her life. I have known a patient drift into that condition and not leave her room for twenty years; she liked the habit of living in retreat. One use of the Nursing Home is: You are called suddenly to see a woman who has become insane. Pending a decision as to the future, it is extremely convenient to be able to say: "Yes, the doctor thinks that a rest would be good for you, therefore you must go to bed, and you must have a nurse." That,of course, is watching to see which way the current is going to run.

Next, as to treatment by drugs. Nowadays people are apt to disparage drugs and drug treatment, but there is no doubt they are useful in some cases of mental disorder. They may prevent, or may shorten, a breakdown, or they may alleviate it in some way. I remember the day when patients were kept quiet by antimony and purges. That is no better than mechanical restraint; we have got past chains, sudden baths, shower-baths, and electricity. But it is important to remember that purges may be essential. I have known a person freed of his delusions by a very copious action of the bowels. You may need to purge so that you may be sure you are starting fairly. And in regard to sedatives, there seems to prevail a sort of healthy dread. In regard to half the patients I see in consultation the doctor says he is not giving anything to induce sleep. That may be right in principle, but no principle is right if you dogmatise on it too absolutely. If you have a patient suffering from sleeplessness, it is your duty to procure him sleep somehow. Nowadays the latest drug is always the best—veronal, or trional. Paraldehyde is the nastiest, and, therefore, in many cases, the best. Both bromide and chloral are given less than they were. Alter the diet, see that the patient does not take so much tea and coffee. If the patient has his last meal at 6 or 7 and goes to bed at 10.30, it is well to give a little hot soup, or something of the sort, with a little stimulant in it. Sleeplessness, especially in old age, is frequently relieved by stimulants.

Baths at one time were much used, and in two or three ways. The old brutal method was the "surprise bath," intended more as a punitive than as a therapeutic measure. In some cases, especially adolescents, a warm or hot bath, with a cold effusion to the head and neck, is useful; and very violent patients have derived much benefit from the prolonged bath, which can be readily arranged in any house. At Bethlem I have kept patients in such a bath eight or nine hours, and they frequently calm down quickly, when everything else has failed. In cases of chronic sleeplessness, it is good to add to the hot bath ¼ lb. of mustard to which has been poured a quart of boiling water, first letting it stand for ten minutes. Turkish baths are sometimes useful.

I have no experience of the subcutaneous injection of saline fluids.

Finally, I may say, I never, or very rarely, neglect to reason with my patients. (Dr. Savage gave instances of good results from this.) As to hypnotism, that is a subject large enough for a separate lecture. But hypnotism would do harm in patients who are emotional and already too sensitive. However, it is often successful in inducing sleep in those who badly need it. Sometimes delusions are shifted by hypnotic suggestion. Society is very much alert on the subject of prophylaxis, but we have not got so far as our American friends, and I do not think we ever shall: "Although it is desirable for the good of the community that only individuals who are mentally sound should propagate their kind, it is scarcely to be expected that the passage of laws similar to the one in Minnesota will in any degree do away with the possibility of marriages, even amongst those who are mentally defective. Hence we are left with only two methods by which these doctrines can be met, namely, ample provision for the poor unfortunates in institutions, or, if they be left at large, castration."

NOTE.—*A Clinical Lecture, by a well-known teacher, appears in each number of this journal. The lecture for next week will be by R. J. Kinkead, M.D., Dub., L.R.C.S.I., Professor of Obstetrics in Queen's College, Galway: Physician and Gynæcologist to the Galway Hospital. Subject; "The Consequences and Treatment of Laceration of the Female Perineum."*

ORIGINAL PAPERS.

RHEUMATOID ARTHRITIS

AND THE MORBID CONDITIONS WHICH SIMULATE IT; WITH SPECIAL REFERENCE TO PATHOLOGY AND TREATMENT. (*a*)

By ARTHUR P. LUFF, M.D., B.Sc., F.R.CP. (LOND.),

Physician to St. Mary's Hospital.

THE term "rheumatoid arthritis" is objectionable, as suggesting a causal connection with rheumatism. If, however, it is employed and understood as merely meaning an arthritis somewhat resembling some forms of rheumatism, the term may be retained, although the name "arthritis deformans" is less open to objection. I suggest, however, in this discussion that we retain the term "rheumatoid arthritis" owing to its long usage, as I am afraid that the description of the disease under another and less recognised name may lead to confusion.

Rheumatoid arthritis is held by some to be a very complex disorder which has many factors concerned in its etiology. I do not hold with this view. My own opinion is that although there are several infective diseases of the joints which somewhat resemble it, yet that rheumatoid arthritis is a distinct clinical entity, which, with care, may be distinguished from other forms of arthritis.

Rheumatoid arthritis is a constitutional disease, not a local one—the affection of the joints is only a part, although an important part, of the morbid process. It is, I believe, a disease due to the presence of micro-organisms which gain access to the blood in the majority of cases probably through some chronic catarrh of the alimentary tract, although the invasion may occur from the nose, pharynx, or air tubes. After gaining access to the circulation they find a suitable nidus for their growth in the joints, where they grow and propagate in the synovial membranes, ligaments, cartilages, and bones. As a result of their presence inflammatory changes occur which result in ulceration, erosion, destruction, and, coincidently as a rule, in hypertrophy also. During the active growth of these micro-organisms toxins are produced and discharged into the circulation, and by their action on the nervous system give rise to the nervous symptoms of the disease, while the toxins acting on the vasomotor nerves and the trophic nerves of the skin produce the local sweatings and pigmentation which occur in connection with rheumatoid arthritis.

That it is an infective disease is shown by the febrile disturbance, which, although not severe, always accompanies the early stages of the disease, by the rapidity of the pulse, the local sweating of the hands and feet, and by the progressive involvement of many joints. In its early stages it may very closely simulate subacute rheumatic fever, but it may be distinguished from it by not reacting to treatment wth salicylates. The disease usually commences in one joint, commonly one of the metacarpo-phalangeal articulations, and then rapidly spreads to other joints. Shortly after its commencement it is always polyarticular. The so-called forms of monarticular rheumatoid arthritis are, in my opinion, always traumatic in origin, and are due to degenerative changes set up within the joint as the result of chronic inflammatory processes which result in the disintegration and wearing away of the joint cartilage. It would be better, I think, to restrict to these forms the name "osteo-arthritis."

Rheumatoid arthritis occurs in two forms—acute and chronic. Both are due to the same infective cause and simply differ, as regards their clinical features, in the degree or virulence of the infection, or in the different results of a similar process attacking the joints at different ages. It is commoner in females than males. In the acute form it is generally met with in earlier adult life. The chronic form may be a later stage of the acute disease, or, as is more frequently the case, it is chronic from the first, and occurs especially in middle life and in females. In the latter it is specially prone to start about the climacteric period. Comparatively slight injuries of a joint, especially of a small joint, may lead to rheumatoid arthritis, and to an extension of the process to other joints in a symmetrical order. The injuries are frequently the outcome of excessive work and strain, especially in elderly and enfeebled persons with a diminished power of resistance, increasing with years, and with imperfect nutrition.

In the acute form the synovial membranes are primarily and mainly affected, while the ligaments are softened and infiltrated, presenting the well-known spindle-shaped enlargements of the joints. The cartilages are damaged secondarily, and it is not until the disease has assumed the chronic form that the signs indicative of destruction of cartilage become evident, accompanied with cartilaginous and osteophytic outgrowths.

Cases of Heberden's nodes represent the mildest degree of the disease. The nodes consist of little hard swellings of the finger joints, affecting almost entirely the terminal phalangeal, and are due to a very chronic form of rheumatoid arthritis. This type is more commonly met with in women than in men, and usually at or after the middle period of life. The nodules are due to enlargement of the ends of the bones, which are frequently covered by a pouch of the projecting synovial membrane, which acts somewhat as a bursa. The joints become swollen and tender. The cartilages are softened, and the ends of the bones are eburnated. The enlargements are osseous in character, but there may be a certain

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(*a*) Opening of Discussion in the Section of Medicine at the Exeter meeting of the British Medical Association, August, 1907.

amount of increase of the periarticular fibrous tissues. After a time the disease usually becomes arrested, but the swellings remain, and eventually may cause no discomfort.

In the great majority of cases rheumatoid arthritis is a primary disease, but at the same time it is probable that in a small number of cases an antecedent attack of rheumatic fever, or of some form of septic arthritis, such as gonorrhœal arthritis, or even an acute attack of gout, may have left the joints in such a vulnerable condition that they may subsequently become the seat of true rheumatoid arthritis. Any debilitating condition may predispose to this disease, and especially of late years I have seen many cases of rheumatoid arthritis which have followed repeated attacks of influenza.

Treatment.—Rheumatoid arthritis, if left untreated, tends to spread from joint to joint, and produces progressive destruction of the joint tissues. Occasionally treatment fails to effect any arrest of the disease, and this is especially apt to occur in connection with the rheumatoid arthritis of the old. For the successful treatment of this disease it is essential that the treatment should be commenced while the disease is in its early stages; hence the importance of an early recognition of the malady, and of its distinction from gout and rheumatism. The treatment must be persevered in for a long period of time, generally a year or two, and during the treatment everything possible must be done to increase the patient's strength, and to maintain the general condition of nutrition at the highest possible level.

If rheumatoid arthritis is seen and recognised early in the acute stage it is curable. In the later chronic stages it is possible to arrest the disease, to remove the pain, and to secure greater movement of the joints; but it is not possible to bring the disorganised and deformed joints back to their normal state. It is remarkable, however, even in many chronic cases, what a considerable amount of improvement may be effected in the joints if suitable treatment is persevered with for a prolonged period of time.

The not infrequent mistake of diagnosing rheumatoid arthritis as gout, and the consequent placing of the patient on a restricted and spare diet, has undoubtedly led to the development of severe and incurable forms of the disease. It is essentially a disease that requires good and nutritious feeding, and I have seen many cases of rheumatoid arthritis which have gone thoroughly to the bad, through the initial error of mistaking the disease for gout, and treating it with a spare diet. The diet should be as liberal and as good as the patient can digest, and animal food should be partaken of freely, though not to the exclusion of vegetables. A moderate quantity of wine or stout should be taken with lunch and dinner. Any kind of wine that agrees with the patient may be taken, but perhaps a generous red wine, such as Burgundy, is the most suitable.

The drugs that I have found most useful in the treatment of rheumatoid arthritis are guaiacol and potassium iodide. I have now employed guaiacol in over three thousand cases, and as the result of my experience I do not hesitate to say that, if administered in sufficient quantities and for a sufficiently long period, it is capable in the great majority of cases of arresting the disease, of diminishing the size of the joints, and of permitting increased movements. It also relieves pain markedly. It is useful in both the subacute and chronic forms of rheumatoid arthritis. The guaiacol probably acts by inhibiting the growth of the specific micro-organism in the intestinal tract, and after absorption by combining with the bacterial toxins and assisting in their elimination. It is not to be imagined for one moment that the guaiacol renders the intestinal tract sterile, but just as the administration of cinnamon oil in cases of enteric fever exerts a restraining influence on the propagation of the typhoid bacilli, and renders them less capable of elaborating a virulent toxin, so, I believe, the guaiacol exercises an inhibiting effect upon the micro-organisms responsible for the production of rheumatoid arthritis. The iodide of potassium probably acts by promoting absorption of the hypertrophied fibrous tissues.

The most convenient form of administering the guaiacol is the carbonate in cachêts. This salt is a white powder which is free from the disagreeable odour, taste and irritating effects on the stomach of guaiacol itself. In the intestines it is slowly split up into guaiacol and carbonic acid gas. At first from five to ten grains of the carbonate of guaiacol should be given three times a day, and the dose should be increased by one to two grains each week until from fifteen to twenty grains are being taken in each dose. It is essential that this treatment should be continued for at least twelve months. The beneficial effects of the guaiacol are very much increased by administering at the same time a mixture containing potassium iodide; the depressing effect of the iodide should be counteracted by its combination with tonics.

The treatment that I have just detailed, is, in my experience, incomparably superior to the prolonged treatment for two, three, or more years of such cases with small doses of arsenic and iron, a method of treatment which still has many supporters.

After the treatment with guaiacol carbonate and potassium iodide of a very large number of cases of rheumatoid arthritis I am convinced that it is capable in the great majority of cases of arresting the disease, and so of preventing the frightful suffering connected with movements of the affected joints, a condition which is so common in cases of unrelieved rheumatoid arthritis. If the treatment is commenced in the comparatively early stages of the disease, then recovery with very little deformity may result; but even if after arrest of the disease much deformity results, very considerable mobility of the joints may be promoted by baths, superheated air, massage, and passive movements. It is frequently remarkable to find after such treatment what an amount of mobility and capacity for usefulness has been restored to joints which have been left in a severely deformed but quiescent condition.

The thermal treatment of the affected joints, either by means of baths, superheated air, or electric light baths, is most beneficial. Douche massage is the most effective form of treatment with hot water, and perhaps next to that rank peat baths and brine baths. Electric light baths, in which the affected joints are bathed in the heat and light rays reflected from a number of incandescent electric lamps, are also beneficial in many cases. Properly regulated movements and properly applied massage are of great use in overcoming the stiffening and fixation of the joints, and the muscular wasting in their vicinity.

Climate.—Dry heat benefits cases of rheumatoid arthritis, whereas damp cold increases the disease. Seaside resorts are not suitable for most cases. As a winter resort there is no better climate than that of Egypt.

ON
AUTO-DEFORMITIES OF THE FOOT.

By PAUL GALLOIS, M.D.,
Surgeon to the Paris Hospitals.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

THE perfection to which the hand has attained, making it an incomparable weapon in the struggle for existence has been in great measure rendered possible by the fact that the whole weight of the body falls upon the lower limbs. This weight is a matter of moment, seeing that it averages nine stone. If we suppose a foot 30 cm. long and 10 cm. in breadth at its widest part, this gives us 300 square centimetres, a surface of 300 q.c. for each foot, *i.e.*, 600 q.c. for the two. Every square centimetre of the plantar surface consequently has to support 100 grammes pressure. But if we take the imprint of the moistened foot on a plane surface, we find that only a part of the plantar surface comes into contact with the ground (1) the heel; (2) what has been called the anterior heel, constituted by the metatarso-phalangeal articulations and (3) by a band running along the outer border of the foot joining the anterior and posterior heels.

In standing, a man distributes the weight of his body fairly equally over the various parts of both soles, but this is by no means the case in walking, when necessarily each foot has to bear the whole weight in its turn, and in respect of each foot the weight is successively shifted from the posterior to the anterior heel. Let us assume for instance that the heel measures 6 cm. in length and 5 cm. in width, *i.e.*, 30 q.c. of surface area, it will be seen that at certain moments each square centimetre of the heel surface is called upon to support a weight of two kg. and this weight is notably increased in running and jumping.

Overstrain is a recognised cause of disease in any organ, and it is therefore by no means surprising if persons, who are obliged by their calling to walk a great deal or to stand the livelong day, ultimately suffer from various local disturbances in the feet thus subjected to excessive functional strain. This is so self-evident that it seems almost idle to insist upon the fact, but it has often happened to me to see patients suffering from troubles due to foot fatigue, the existence whereof had been ascribed by their medical advisers to various other causes. In some cases the pain &c., had been ascribed to rheumatism, this refuge of the destitute in diagnosis, and the patients were accordingly stuffed with salicylate. In others, surgical intervention had been proposed yet in all immediate and marked improvement usually followed a period of functional rest. It may therefore be as well, after all, to emphasise this pathogenesis and to discuss the various troubles due to foot fatigue as a whole, so that they may all be grouped under one head.

The term I propose is "auto-deformity of the foot." No doubt the term deformity is rather too strong for certain forms of foot fatigue, and in reality only applies to extreme cases, but on the other hand a milder term would fall short of the graver cases. "Auto-deformity," therefore, seems to me to express with sufficient precision the troubles determined in the bones of the foot by the excessive or unduly prolonged pressure of the weight of the body.

The foot rests on the ground on the anterior and posterior heels, but these two heels are but the pillars of an arch which has to support the direct weight of the body and transmit it to the calcaneum on the one hand and to the heads of the metatarsal bones on the other. This arch comprises the tarsal and metatarsal bones. The troubles induced by the weight of the body may therefore bear on (1) the calcaneum; (2) the tarsal bones; (3) the metatarsal bones; and (4) on the heads of the metatarsal bones which together form the anterior heel. It follows that we have to consider four distinct types.

(1) *Talalgia.*—Talalgia is characterised by a more or less troublesome pain on the plantar aspect of the heel. The pain is felt especially when standing, and may be elicited by pressure with the finger. It may persist even in the absence of pressure. Talalgia is especially frequent in persons who are constrained to the erect position possibly more than in those who have to walk a great deal. It has been described as "Policeman's Disease." It is also met with in bank messengers, shop employés, omnibus conductors and porters. It may be caused by irregularities in the boots throwing the weight of the body on a part only, instead of the whole, of the calcaneum. This bone, which is in this way subjected to a sort of perpetual bruising, becomes painful. Now, as a general rule, once a bone has become painful it remains so for a long time. Talalgia was attributed by Jacquet to gonorrhœa which he claimed gave rise to hyperosteosis of the calcaneum. I am not disposed to deny this possibility but I cannot say that I have ever observed an example thereof, although my attention was long since drawn to the question. On the contrary the perpetual bruising of the calcaneum appears to me to be a much more frequent cause. Some practitioners attribute the pain to rheumatism and have recourse to the salicylates which rarely give any result worth speaking of. Enterprising surgeons, having discovered the existence of abnormal prominences on the calcaneum, have gone so far as to propose partial resection of the bone. The conception of chronic bruising infers much milder measures. All we have to do is to get the patient to change his occupation if that be possible. Otherwise we must advise him to wear rubber soles inside his boots or to fix rubber heels outside, these articles being now on sale everywhere.

(2) *Tarsalgia.*—Tarsalgia occurs in all degrees of severity. In slight cases, which are the most frequent, patients complain of pain in the instep. If we run the finger over the arch in order to make out the exact spot it will usually be found on the inner side of the foot opposite the inter-articular spaces separating the first cuneiform from the scaphoid or the first metatarsal. This mild form of tarsalgia is generally ascribed to ordinary rheumatism.

A more advanced form is that of "adolescent tarsalgia," or flat-foot. Years ago Gosselin attributed it to contraction of the lateral peronei, but at present the theory of auto-deformity is generally admitted, and A. Broca in particular fully adopts this explanation in his treatise on children's diseases. Crushed by the weight of the body, the plantar arch gives way. Coincidently with the flattening of the foot the scaphoid is displaced inwards, and its normal prominence becomes unduly pronounced. In flat-foot of old standing the pain is often but slight, and patients suffering therefrom, in spite of the deformity, are very good walkers. This form is very frequently met with in Arabs. Tarsalgia with flat-foot is particularly frequent at adolescence at a time when the body is rapidly increasing in size and weight, and the bones of the foot become lengthened, although retaining an infantile consistency. The treatment consists in supporting the plantar arch either by insisting on boots that hold the foot well together, thickened on the inside, corresponding to the arch, or by using pieces of cork or rubber modelled to the normal arch, or metal supports of the same kind. Simple or comparative rest, however, often suffices to effect a cure.

The grave form of tarsalgia is that associated with tabes. The mechanism is the same, but as the bones in ataxic subjects are abnormally fragile they do not merely slide one over the other, but they give way and break, with a sudden yielding of the arch, the fractured ends uniting with deforming callus.

(3) *Metatarsalgia.* This type of crushed foot is well-known to military surgeons under the name of "forced foot." It is an acute accident characterised by sudden painful swelling of the foot over the metatarsal bones. Skiagraphy, confirming what had already been suspected, has enabled us to distinguish a fracture usually of the fourth metatarsal bone.

It may be asked why this metatarsal bone should be affected in preference to any of the others. A fracture of the internal or external metatarsal bone would be easier to understand but the first metatarsal bone is very strong and the fifth is also fairly resistent, moreover it rests its whole length on the ground as shown by the footprint. It follows that these two metatarsal bones are likely to resist the crushing influence. As to the three intermediate metatarsals they are approximately of the same size, yet the fourth is, if anything, rather smaller. Moreover, we must bear in mind that the metatarsal bones taken together represent an arch, not like the instep antero-posterior, but transverse. It is the heads of the first and fifth metatarsal bones that rest on the ground, as anyone can see for himself if he examines a normal plantar surface. The skin over them is thicker and the fatty padding is more marked. On dissection we find bursæ over them, indicating that these are the two bones that do most of the work. Now when the foot is fatigued by long marches, as in soldiers who have, moreover, to carry a knapsack, this transverse arch gives way, and of the three middle metatarsal bones which are less protected and less strong than the others, the first to come into contact with the ground is the fourth, hence the frequency with which it is fractured.

(4) *Morton's Neuralgia.* In the affection known under this name it is again the fourth metatarsal bone that is the seat of pain, opposite to its articulation with the phalanx. When chronic the mechanism is the same as in "forced foot." There is also some relaxation of the ligaments binding together the metatarso-phalangeal articulations, with flattening of the transverse arch, bringing the head of the fourth metatarsal bone into contact with the ground, and as it is less protected the chronic bruising to which it is subjected provokes an abnormal pain similar to that in the calcaneum in ordinary talalgia, in other words it is an anterior talalgia.

The theory of neuralgia infers that the nerve filaments are compressed between the heads of the fourth and fifth metatarsal bones and the advice usually given is to wear wide boots with thin soles, or light slippers. But in reality it is better to have thick soles, thus distributing the pressure over the anterior heel and keeping the fore part of the foot rather tightly bound so as to reform the arch of the anterior heel. In some instances a simple ribband tied round the metatarso-phalangeal articulations will suffice to give relief.

Rest is obviously the best way to effect a cure, but we must remember that, just as in talalgia of the calcaneum, the pain induced by bruising of bone is usually very persistent and subsides but slowly. Surgical operation, resection of the head of the painful metatarsal bone, has been proposed in Morton's neuralgia, just as in talalgia.

It will be seen then that overstrain of the foot determines various deformities of the bony framework of the foot. By considering them together we are better enabled to appreciate the mechanism of their pathology. It is important to recognise them properly, if only to avoid useless medical treatments and uncalled-for surgical interventions. They may be improved by various modifications of the foot gear, by massage, electricity, baths, and the administration of phosphate of lime, but we must at all times bear in mind that there is really only one effectual means, viz., rest.

THE MEDICAL ASPECT OF DENTAL CARIES IN CHILDHOOD. (*a*)

By G. F. STILL, M.A., M.D., F.R.C.P.,

Professor of Diseases of Children, King's College, London: Physician for Diseases of Children, King's College Hospital; Assistant Physician to the Hospital for Sick Children, Great Ormond Street.

Caries of the teeth is an important cause of ill-health in children, and one which is apt to be overlooked; the converse is also true that ill-health in children is a cause of dental decay. Decayed teeth interfere with the proper assimilation of food, and such interference is most serious in childhood when growth and development, physical and mental, should be at their greatest activity. Any widespread prevalence of dental decay in childhood is a menace to our national physique. A series of observations taken amongst children brought to hospital for other conditions showed that 82·7 per cent. of children between 5 and 12 years of age had decayed teeth, and 39·8 per cent of children between two and five years old. Some of these children had 10–15 carious teeth.

Parents as well as medical men ought to know how much a child's health may suffer from decayed teeth. The commonest evil therefrom is digestive disorder, and this in a child is often shown by loss of flesh, loss of appetite, enlargement of the abdomen, and sometimes by frequent pains in the abdomen. Anæmia is also sometimes due to dental caries, perhaps in consequence of chronic poisoning from the foul condition of the

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(*a*) **Abstract of paper read before the Dental Section at the Exeter meeting of the British Medical Association, August, 1907.**

teeth. Decayed teeth also form a nidus for micro-organisms which may set up inflammatory disorders in the mouth or pass into the blood or into the neighbouring glands and produce more serious disease. It has been thought that tuberculous disease of the glands in the neck may arise from infection from decayed teeth; the tubercle bacillus has been found in decayed teeth, and enlargement of glands is very frequently associated with decayed teeth, but it is very uncertain how often any tuberculous infection is due directly to the teeth, for there are other and probably much commoner sources of infection; but there can be little doubt that indirectly by causing swelling of the glands dental caries is a powerful predisposing cause of tuberculous infection of these glands.

Decayed teeth are also a cause of frequent headaches in some children, and occasionally give rise to more troublesome nervous disorder such as habit spasm, and in a few recorded cases even epilepsy.

Lack of proper cleaning of the teeth is one factor, but not the only one, in the production of dental decay. Considerably more than 50 per cent. of children of the hospital class at the school age have never cleaned their teeth in their lives. But it has been shown that children of the well-to-do classes are just as liable to dental caries as the poorer and less well-cared for children, and whilst the most scrupulous cleanliness will not always prevent decay, complete ignorance of a tooth-brush is not inconsistent with a perfect set of teeth.

There are differences in the teeth of different children; in one the enamel is thicker and more perfectly formed than in another, and this difference may be congenital and perhaps peculiar to particular families so that the children of one family may have teeth more resistant to decay than those of another family; but imperfect development of the teeth, particularly of the enamel, may be due to preventable disease, namely rickets: and any profound disturbance of nutrition in infancy, such as is produced by improper feeding, may interfere with the perfect development of the teeth and so make them more liable to decay.

Diet has some influence in producing decay of the teeth after they have already been cut, but probably this influence is chiefly indirect; any food which causes digestive disorder, thereby alters the secretions of the mouth so as to favour the action of bacteria in producing fermentation and eroding the enamel. Sweets, which are generally supposed to harm the teeth, probably do so only in this indirect manner, for, given at wrong times and too frequently they are specially apt to upset digestion.

The prevention of dental caries must date from earliest infancy. If 39·8 per cent. of children between two and five years of age have decayed teeth, it is evident that the mischief is often present before the school age, and no dental inspection of schools can take the place of parental care in preventing this evil. Proper feeding in infancy and the prevention of rickets and of digestive disturbances in early life are of prime importance. The teeth from their earliest appearance, should be cleaned twice daily, especially in the evening.

There is a most erroneous and mischievous idea current that decay of the first teeth is of little importance, whereas it is probably more liable to injure the general health and the physical development then than at any other period of life. If parents would take their children regularly to a dentist for inspection two or three times a year, and if dentists would see that decayed teeth were stopped whenever possible, there would be less ill-health and difficulty of digestion in early childhood, and probably also less decay in the permanent teeth.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

Patient on whom Colotomy had been performed for Intestinal Obstruction.

By J. P. LEGG, M.S., F.R.C.S.

MR. LEGG showed a patient on whom he had performed colotomy for chronic intestinal obstruction more than a year ago. She was a woman, æt. 44, who had suffered from gradually increasing constipation, abdominal pain, and distension during several months previous to the operation. She had lost flesh also to some extent, but was not emaciated. On examination of the abdomen, peristaltic movements of the descending colon and sigmoid were very obvious, and whenever a wave of peristalsis occurred she complained of a certain amount of discomfort and wind which could be heard gurgling in the intestine. Deep down in the left iliac fossa a definite hard mass was discovered which was easily felt in Douglas's pouch on making a vaginal examination. She had had no mucoid or blood-stained discharge from the rectum, which was found to be quite healthy. At the operation it was evidently impossible to do an excision of the growth, and therefore a colotomy into the highest part of the sigmoid was done. As the symptoms were not very urgent, the bowel was not opened till the seventh day. Mr. Legg showed the case, and pointed out the several indications for doing a colotomy, the advantages and disadvantages of the operation. As regards the indications, he said, this woman furnished a typical example of a patient suffering from intestinal obstruction with an irremovable growth, and it was important to remember that the obstruction was the chief factor in influencing the surgeon to do a colotomy. Many patients had an irremovable growth in the rectum, but this fact alone was not a sufficient indication for the performance of this operation. Before advising such patients to have a colotomy, the symptoms which the malignant disease was causing had to be carefully considered. Thus, if a growth was extensively ulcerated and there was a constant discharge of bloody mucus from the anus, or if the patient was suffering from diarrhœa and very severe pain caused by the ulceration colotomy was frequently of great value in relieving the symptoms. One had also always to remember that at most colotomy was only a palliative operation, and although patients frequently obtained a certain degree of control over the artificial anus, yet that control was never perfect and the presence of the colotomy might add to the discomforts of the patient without relieving the symptoms if it was done in unsuitable cases. In doing the operation, an essential feature was to obtain a good spur separating the upper from the lower opening in the bowel. Then, it should be done through as small an incision as possible, and the lowest part of the descending colon or the highest part of the sigmoid should be fixed to the parietes, thereby lessening the chance of the formation of a ventral hernia and of prolapse of the intestine through the incision. In order to obtain a good spur, a V-shaped loop of the intestine must be brought out on to the abdominal parietes and the meso-sigmoid transfixed by a suture, which also fixes the two sides of the incision to each side of the mesentery, and in order to increase the chances of the patient having more perfect control over the passages of the fæces, it was a good plan to split the muscles of the abdominal parietes in the direction of their fibres rather than to cut straight through them. Mr. Legg, however, was inclined to attach more importance in this respect to obtain a good spur separating the two openings in the bowel; both openings were circular in shape and were completely surrounded by the muscular coats of the intestine, and if the surgeon's finger was inserted into the orifices it was easy to feel the grip or contraction of the muscle fibres. As in this patient, the skin around a satisfactory colotomy should be quite healthy, not red or excoriated, and, as in this patient, the colotomy should not require dressing more than twice a day. To further add to the comfort of the patient, it was a very good plan to irrigate the lower piece of bowel, namely, that to which the growth was still connected, either through the lower colotomy opening or through the anus. By this means the discharges from the growth were washed away every day. A belt of some sort was necessary, and he thought the most convenient and useful, most easily kept clean, was one in which there was a thick glass reservoir covering the openings into the bowel Plugs fitting into the apertures should not be used, and if the operation was done as described in this case there was no tendency for a stricture of the orifices to form. The woman as now seen was in very good health; she had been able to do her work as a caretaker in a large warehouse for the past seven months. The skin around the colotomy was quite healthy, there was no prolapse, and only a slight amount of bulging of the scar. The colotomy, she said, acted two or three times a day, and she knew when it was going to act if the bowels were not relaxed from any cause, and this, she asserted, rarely happened. On making a vaginal examination the growth did not appear to have extended, and there was no evidence of secondary growth in the liver, although it was more than a year since the colotomy was done. Mr. Legg pointed out that carcinomata of this type found in the sigmoid were not so malignant as other carcinomata of the rectum, and, as a rule, can be excised with or without a colotomy; in this particular instance the growth was not excised because it had infiltrated an adjacent portion of small intestine and was closely bound down to the pelvic walls. He added that such growths were the commonest cause of chronic intestinal obstruction in people æt. over 40.

OPERATING THEATRES.

KENSINGTON GENERAL HOSPITAL.

Nephropexy: Spinal Analgesia.—**Mr. Canny Ryall** operated on a woman, æt. 40, who had been admitted suffering from movable right kidney. For some years the patient had had all the cardinal symptoms of this affection, but the usual nervous symptoms, which are so often met with in these cases, were absent. The patient was seated on the operating table with the shoulders well arched, the skin over the lumbar spinous processes, which had been previously prepared, was now thoroughly swabbed with alcohol, then frozen with ethyl chloride. A puncture was then made with Mr. Canny Ryall's puncture knife and the platinum iridium needle of his apparatus for spinal analgesia was next inserted into the spinal canal through the median plane; cerebro-spinal fluid at once flowed in a good stream, and 10 cc. were withdrawn. A 1 per cent. solution of novocain with synthetical suprarenin was injected. The patient was kept seated in the vertical position for five minutes, and then placed on her left side with a sand-bag under her loin, and the usual oblique incision immediately below the last rib was made. The kidney having been rapidly exposed and drawn through the wound, a narrow strip of the capsule was raised from the lower to the upper pole of the kidney and twisted into a cord. A blunt needle was then passed beneath the skin from without inwards over the last rib, the twisted portion of capsule was next threaded through the eye, withdrawn from within outwards, and securely fixed to the adjacent muscular tissue. It was then seen that by this means the kidney was well slung. In addition the remaining part of the capsule on its posterior aspect was divided transversely: this enabled four flaps of the capsule to be raised, which were fixed with catgut to the adjacent muscles. It was now apparent that the kidney was securely placed in a high position. The wound was then closed. Mr. Canny Ryall said that the first point to be noticed was the sleepy condition of the patient when she was brought into the theatre: this was due to her having previously had two injections of scopalamin and morphia, given, the first two hours before, the second one hour before the operation. In some cases he gave three injections. He pointed out that he now always uses scopalamin and morphia in conjunction with novocain for operations on the gall bladder, the stomach and kidneys, also for hysterectomies, and where it is anticipated peritoneal adhesions exist. In the first place the lumbar puncture should be made in the median line, and not to one side of it, as it is sometimes done by surgeons in this country. If the lateral method is employed semi-analgesia or imperfect analgesia may be the result; the advantages in his opinion of median puncture are that one always gets perfect analgesia, and there is no risk of injuring the cauda equinia. He said he was the first surgeon in this country to use novocain for the production of spinal analgesia; also synthetical suprarenin in conjunction with it, as well as scopalamin and morphia as an adjunct for higher operations in the abdominal cavity. He stated that he could not speak strongly enough in favour of spinal analgesia, for, of all methods for combatting shock, none could compare with this one. It was particularly indicated in patients suffering from heart disease, diabetes, alcoholism, for aged people, for those suffering from shock following injuries to the abdomen and lower extremities, or in operations such as excision of the rectum, strangulated hernias, hysterectomies, amputations of the thigh, prostatectomies, and to ward off the shock which so commonly follows these operations. He had performed all these operations with analgesia produced by this method, and was particularly struck by the absence of subsequent shock. As regards drugs for spinal injection, surgeons had novocain, stovain, tropococaine and alypin' to choose from, all of which had been discovered within the last few years. Novocain, in his opinion, was far superior to any of the others. He had used a 10 per cent., 5 per cent., 2 per cent., and now only employed a 1 per cent. solution of novocain. In general anæsthesia the rule was to use as little ether or chloroform as possible, and going on these lines for spinal analgesia, he now worked with a 1 per cent. solution of novocain in conjunction with synthetical suprarenin, which gave perfect results. He considered that the duty of injecting the patient should fall to the lot of the ordinary anæsthetist, provided that he (the anæsthetist) was well versed in aseptic measures, and the duty of the anæsthetist after the injection would be to keep the patient's attention occupied by continuous conversation. Mr. Canny Ryall would advise chloroformists to practise lumbar puncture on the dead body before performing it on the living; he said spinal analgesia should never be carried out in acute septic or infective cases.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Aug. 11th, 1907.

Exophthalmic Goitre.

The first complete description of exophthalmic goitre was due to the celebrated physician, J. P. Graves, and to a German doctor, Basedow; consequently this affection is frequently called Graves', or Basedow's, disease. These two authors, whose publications date as far back as 1840 and 1843, had, however, some predecessors amongst whom may be cited Parry (1825) and Flagani (1802), an Italian. In Italy it is still called Flagani's disease.

In France, the clinical lectures of Trousseau and the publications of Charcot, Rendu Marie and Bellet, made known the symptomatology of exophthalmic goitre.

Goitre, exophthalmia, tachycardia, trembling, such are the four essential signs of Graves' disease. These symptoms are not, however, of equal value, for in the attenuated form certain of them may be absent; but the most constant is tachycardia or cardiac palpitation.

Exophthalmic goitre is most frequent in women; rare before puberty, it is exceptional after the age of fifty.

Cardio-vascular troubles are generally the first symptoms observed; the others develop little by little.

In very rare cases, the initial symptoms set in very suddenly, but even here, intelligent questioning of the patient will reveal that the malady had already set in by slight signs which had passed unperceived.

Yet there are on record certain cases where the attack came on suddenly from violent emotions. Trousseau relates the case of a woman who had lost her father, to whom she was greatly attached. In one night that the patient had passed in weeping, she felt all of a sudden her eyes swelling so as to prevent her from closing the eyelids, the thyroid gland developing considerably and violent palpitations. Dieulafoy mentions a similar case provoked also by a violent emotion. However, in the immense majority of the cases, the disease sets in gradually.

Hypertrophy of the thyroid gland generally begins insidiously, and it is not until after some months that the patients remark that the front of the neck is somewhat enlarged. It rarely attains a considerable volume, and sometimes it is hardly visible, palpation alone permitting to assure oneself of the extent of the hypertrophy. Both lobes of the thyroid gland may be affected, but that on the right side is always the larger. In any case, the degree of consistence and the volume vary from one moment to another; an attack of palpitations, deep emotion, anger, are sufficient to provoke a notable increase in the dimensions of the gland. The tumour is pulsatile, animated with a movement of expansion at each contraction of the heart. These pulsations are a distinctive sign, as they are not found in ordinary goitre.

Exophthalmia is the most inconstant of the four cardinal signs of the disease, but where it exists it does not fail to draw immediate attention by the strange look it gives to the physiognomy.

Many patients, says Trousseau, affected with exophthalmic goitre come to consult for palpitations of the heart; but the strange look on their faces, seeming to express both astonishment and fright, will soon attract attention and render the diagnosis easy.

When the exophthalmia is very accentuated, complete occlusion of the eyes becomes impossible even during sleep; the cornea remains exposed and is only protected by the lacrymal hyper-secretion which is generally produced; but if this secretion ceases, the cornea dries up and sometimes becomes infected and ulcerates. Grave lesions may be the result.

In every patient suffering from Basedow's disease, three symptoms should be sought for which generally accompany exophthalmia, and although they are not always present, they are of a certain importance. The most frequent of these symptoms is the sign of Graefe, which is characterised by a want of synergia of the movements of the eyelids and the ocular globe; when the patient looks up or down, the movement of the eyelid is slower than that of the eyeball. The sign of Stellwag is less frequent; it consists in a considerable enlargement of the palpebral slit and in the incomplete occlusion of the eyes when the patient thinks he has closed them.

The third symptom, or sign of Möbius, is characterised by the difficulty or impossibility of converging the eyes.

The cardiac troubles drew the attention of the first authors, and in reality they constitute the most constant symptoms and in general the most precocious of exophthalmic goitre; the patients nearly all begin by complaining of palpitations, which are sometimes violent and prolonged, causing a bulging forward of the thoracic wall and the heart-beat against the chest is so considerable that it can be heard sometimes at a distance.

These palpitations become more frequent and stronger under the influence of moral emotions or effort. The pulsations of the carotids are stronger than in the normal state, and are a cause as well as the jugular veins, of the bruit perceived over the thyroid tumour

They are not permanent, but come on in the form of attacks, provoked by moral emotions and efforts. They are generally accompanied by a temporary dilatation of the heart. True hypertrophy of the heart is rare. Auscultation reveals an acceleration of the heart-beats and frequently a souffle extracardiac.

Trembling in exophthalmic goitre was described by Charcot and Pierre Marie. The patient, said P. Marie, is in a state of continual vibration, standing or sitting, the body is animated with a perpetual tremulation, and all the surface of the body is the seat of a kind of general palpitation of a very singular character. It affects the body, head, and, above all, the hands.

Sometimes, it is localised to the extremities, the hands; but the whole hand, and not as in hard drinkers, individual trembling of the fingers.

Other very important symptoms, although secondary and inconstant, may be found grouped around Graves' disease. Those belonging to the nervous system take the first rank: paresia, asthenia, paraplegia, pseudochorea, cephalalgia, rachialgia, neuralgia. Psychic troubles are nearly always constant. From the very beginning, says M. Boix, frequently before the cardinal symptoms have commenced to reveal themselves, the patients show signs of a particular mental condition. They are tormented by an indefinable agitation; their sensitiveness knows no moderation, marks of joy and sadness are excessive, and without proportion with the motives and even without motive. They pass without transition from enthusiastic gaiety to bitterness and discouragement. Ideas rush upon them in quick succession, and are ever changing; they speak with volubility, and are haunted with an uncontrollable desire to be doing something; they cannot keep quiet. At the same time, their character sours; they become difficult to live with. Impatient and irascible, they break out at the slightest contradiction; they are never satisfied, nor ever grateful for any services rendered them.

GERMANY.

Berlin, Aug. 11th, 1907

At the Verein für Innere Medizin, Hr. Hans. Hirscfeld showed preparations from a case of

Poisoning by Chlorate of Potash.

He said the preparations showed not only the known changes in the red blood corpuscles, but also changes in the white corpuscles that had not been hitherto described. The case was that of a girl, æt. 19, who had taken 20grm. of chlorate of potash on June 4th, and was admitted into hospital two days later. She was dull, had the typical blue-grey colouration of the skin, the corneæ were icteric, the urine scanty, dark brown, and containing a large quantity of methæmoglobin. After venesection, performed at once, followed by transfusion of human defibrinated blood, there was slight improvement. During the following days the excretion of urine was scanty, œdema and vomiting were present, and there were also signs of cardiac failure. The treatment consisted in saline infusions, hot baths, injections of pilocarpine and inhalation of oxygen. Death took place on the ninth day after the poisoning. On the first day, the red blood corpuscles showed discolouration of the stroma, within, small nuclei containing a large quantity of methæmoglobine; many had escaped, and were floating free in the blood plasma. On the fourth day of observation red cells were no longer seen undergoing the process of destruction; the number of erythrocytes, 1,500,000; of leucocytes, 15,000; neutrophile hyperleucocytcsis, also myelocytes. Repeatedly leucocytes with polymorphous nuclei were observed, the remains of red blood corpuscles. Besides this, cells with distinct alteration of the neutrophile granula were seen (swelling or destruction); further, neutrophile elements, with clubbed nuclei, *i.e.*, a number of globular structureless nuclei intensely coloured; such cells had never been described as seen in the blood, but in pus, and especially in that of gonorrhœa. Further, quite small cells with round nuclei containing neutrophile granula, which were identical with Ehrlich's pseudolymphocytes. Ehrlich had only once seen them in the blood—in a case of hæmorrhagic smallpox. Lastly, neutrophile cells containing polymorphous nuclei, were very singular, as also some large mononuclear elements which contained from one to several large colourless vacuoles. The speaker believed these were cells that had eaten up red blood corpuscles or their remains; the vacuoles remaining at the spot where this nutrient material lay. It was in favour of this that here and there small fragments containing hæmoglobine still remained in them. That these structural anomalies which had been already described as being present in pus were present also in the blood had not before been recorded.

Hr. Hans Kohn demonstrated preparations from a case of

General Melanosarcomatosis

(liver, lungs, pleura, spinal column, skull, brain, suprarenal capsules, intestine, and uterus) in which the starting point from a pigmented organ was not demonstrable (the suprarenal capsules contained only metastases), and two nævi could not be looked on as point of origin as they had a perfectly harmless appearance and other pigmented organs, such as the choroids were healthy. For this reason the question pressed as to whether if such a starting-point in a pigmented organ was necessary, the pigment may not be developed in the organ itself, as a result of some chemical process. That pigment may develope from chemical causes, Addison's disease and other cachectic pigmentations showed. One might think that a chemical cause perhaps a special ferment, might lead to the formation of a pigment out of the albumen of the tumour. It was in favour of this that in similar cases many tumour nodules were strongly pigmented, many only in part, and others not at all. The liquefying also of many nodules spoke in favour of a fermentive process. V. Fuerth also had made a certain ferment responsible and had assumed that tyrosinase, acting on tyrosine and other hydrochloric substances of the aromatic series formed pigment, and Gessard claimed that he had found tyrosinase and tyrosine in a melanotic carcoma of a horse.

Hr. Westenhoeffer remarked that he had seen a similar case along with V. Leyden. It led a rapid course, and terminated fatally under febrile symptoms in three weeks. What was the course in the case shown?

Hr. Kohn replied that the case ended fatally after a six to eight weeks' febrile course.

AUSTRIA.

Vienna, Aug. 11th, 1907.

Secondary Vaccination.

At the Gesellschaft für Innere Medicin Friejung presented a four-year-old child with a perfect vesicle on the face, the result of contact with her younger brother. The transmission seems to have taken place thirteen days after the vaccination of her brother, which was looked on as very late, and rather remarkable.

Meningo-Cocci Serum.

Jehle showed a case of cerebro-spinalis which he had successfully treated with meningo-cocci serum, according to Paltauf's theory. About seventy-two hours after the disease had declared itself lumbar puncture was made and 20 cubic centimetres of cloudy purulent matter withdrawn which, the microscope demonstrated, held large quantities of meningo-cocci. Twenty cubic centimetres, *i.e.*, the whole of the fluid, was intra-durally injected, after which the temperature fell within twelve hours from 40° centigr. to 36.4° centigr., but the stiffness in neck remained unchanged. The fluid from the lumbar punctures which were made on the next two days was free from all trace of the cocci as far as the microscope could discern, but by cultivation a few tiny colonies presented themselves. About forty-eight hours after the first injection the temperature again rose to 39.2° centigr., but on the following day fell to 36.8° centigr. In the evening of this same day the temperature rose again to 39.3° centigr. with increased stiffness of the neck. Another serum injection (freed from the cloudy purulent matter), containing 30 cubic centimetres this time, was injected which brought the temperature to a normal state, relieving all the stiffness from the neck and, twenty-four hours afterwards, the patient was apparently quite well.

Forty-eight hours after the second injection the fluid extracted by lumbar puncture was perfectly clear and free from any morphological element or bacteria. On the sixth day of the disease, or three days after the first serum injection, an interesting eruption appeared on the upper part of the left arm covering an area as large as the palm of the hand, and resembling Herpes, which rapidly spread on the following day. The vesicles contained a purulent fluid which contained the meningo-cocci, when examined by the microscope.

Escherich thought these meningo-cocci found in the vesicles had found their way from the circulation as a form of metastasis irritating the trophic nerve and producing the vesicle. He said this experiment was no novelty as he had been practising this for some time with perfect success. He had used different meningo-cocci sera, but more particularly Jochmann and Ruppel's better known to the Austrian Sera-therapists. He usually injected 10 to 20 centimetres intra-durally at the earliest moment after diagnosis was complete and before any cerebral destruction took place. In slight or moderate cases the favourable effects are early observed by a rapid fall of the temperature, disappearance of the delirium, and relaxation of the stiffness in the neck—sometimes a perfect recovery within 24 hours. In all cases local disinfecting of the nasal and buccal cavities should be thoroughly carried out.

Disease in the Quadrigemina Region.

Infeld next showed specimens taken from subjects who had suffered from morbid change in the brain in the neighbourhood of the quadrigemina. The first was taken from an old man, æt. 70, who had suffered from an injury to the head when five years old. In life there was paralysis of the trochlear and oculo-motor muscles on the left side, while the right side of the body was atrophied with spastic paresis, disturbed sensibility, and chorea from movements of the paralysed side. There was also hyperflexibility of the fingers, clonic reflex of right leg, but the reflex was absent on the right side of the abdomen, while Babinski phenomenon could not be excited.

The *post-mortem* confirmed the diagnosis of tubercle in the left red neucleus of the quadrigemina.

The second preparation was from a young woman, æt. 25, who had suffered from left otitis, subsequently undergoing operation for radical cure. In life she complained of a numb condition of the left side, diffuse bronchitis, tubercle in the apex of left lung, congestion of the papilla in the fundus of eye, stiffness and feeling of pressure in the neck, vaso-motor disturbance in the skin, hyperæsthesia of the lower half of trunk, marked ptosis of right eye with slight facial paralysis on same side, right papilla wider than left, but reflex lost in both eyes. At an earlier period in the disease, there were right-sided hemianopsia, paralysis of lids, ataxia in the upper extremities, loss of patellar reflex in left leg, but only reduced in right, and no Babinski phenomenon. For two years she had suffered from headache and giddiness, and the last year with vomiting. The *post-mortem* revealed tubercle in the quadrigemina.

HUNGARY.

Budapest, August 11th, 1907.

At the recent meeting of the Budapest Interhospital Association Dr. Bauer exhibited a case of

Sclerosis Multiplex Congenita.

All the chief symptoms consisted in the greater spasticity of the lower and less spasticity of the upper limbs. The deep reflexes were exaggerated. Besides, there was in some measure tremor present, which seemed to be more expressed at intended movements. We are encountering the pathological picture of sclerosis multiplex often enough in old individuals, but it is very seldom seen in children, especially when we can easily diagnose that it is congenital.

Dr. Keller exhibited a case of

Paralysis Progressiva Juvenilis.

In a patient, æt. 19 years, acquired syphilis could be excluded; according to probability nervous disorder of other nature could also be regarded as excluded. Thus we had to assume that the paralysis affected a man who had inherited the tendency, and in whom the disease occurred, on the ground of unknown influences.

Dr. Ivànyi read a paper on the

First Manifestation of Syphilis on the Cheek.

Also in this case, the patient, on account of the extragenital manifestations having been overlooked, came under proper treatment when already infected with grave symptoms. The patient, a female servant, æt. 24 years, was admitted to hospital with general papular syphilides, which had existed for three weeks, while the primary sclerosis on the right cheek and the glands, the size of nuts, on the right side of the neck, had been seen for three months. The patient was not attended to up to this time. The cause of infection could not be detected.

A Case of Spastic Spinal Paralysis.

Dr. Salgo exhibited a patient, æt. 31, who fell ill three years ago with similar symptoms as those complained of at present. Three years ago, after finishing a systematical antisyphilitic cure, the patient has improved so far, that he could follow his vocation without any trouble. At present he can walk only with the aid of a stick, and even so his gait was unsteady, he could not bend his knees, his paces were short, and the feet almost stick to the earth. The knee was stiff, and during the act of walking not only the muscles of the lower limbs became strained, but the exertion was apparent even on the upper limbs, too; besides, walking was uncertain, and on the whole the complexity of symptoms showed that type, which is called by Charcot and Erle, the spastic paretic gait. Beside this paresis of the lower limbs the atrophy of the muscles were absent, even in a lying posture the muscles were able to show considerable strength.

Further, any lesion of sensation and urinary difficulties were absent. However, the general exaggerations of the knee jerks was striking; a slight knocking of the knee tendon resulted in great elevation of the foot. The touching of the Achilles tendon resulted in a clonic spasm. The passive dorsal flexion of the foot was followed by a long-standing clonus. If the sole was touched the toe had a dorsal flexion. (Babinski's symptom).

From these positive and negative symptoms the diagnosis of spastic spinal paralysis was drawn.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

Paintings by a Medical Man.—An interesting exhibition of pictures by the late Dr. James Moore has just been opened in the Municipal Art Gallery at Belfast. Dr. Moore was one of the foremost surgeons in Ulster some thirty years ago, and at the same time an artist of no mean ability. It is said that he never went to a country consultation without carrying a colour-box and sketching-block, with which he filled in many a spare hour when waiting for trains, etc., so that when he died in 1883 he left behind him a great number of sketches and paintings, chiefly of landscape and seascape in Ulster. It is, indeed, by his sketches and by the many tales of his ready wit that he is now remembered. He was a frequent exhibitor at the Royal Hibernian Academy, and was elected an honorary member of that body. He was probably more appreciated in Dublin than in his own city, if one may judge from the story told of a hospital bazaar, for which a lady persuaded him to do several small water-colours, which he expected would sell for about a guinea each. Some time afterwards he met the lady who, with a pleased smile said, " Oh, Dr. Moore, I have sold all your pretty pictures and I I got half-a-crown apiece for them." Few of his pictures have come into the market; but one, "Slieve Bernagh, Mourne Mountains," has lately been acquired by some of his old friends, and has been presented to the Belfast Art Gallery as a permanent memorial of Dr. Moore.

The Corporation and Physical Degeneration.—Some months ago there was some stir in Belfast over a placard issued by the Corporation, and posted all over the city, calling the attention of the people to the conclusions of the Royal Commission on Physical Degeneration on the subject of the abuse of alcohol. The Vintners' Association protested at the time, but after much wordy warfare the placards were eventually issued. But the Vintners still protested, and appealed to the Local Government Auditor, who had disallowed a payment of £10 10s. for the placards, on the ground that he can find no statutory authority for the payment. He has, therefore, surcharged the three members of the Corporation who signed the cheque for the amount, and it now turns out that one of the three was a leading member of the Vintners' Association—a truly Gilbertian conclusion to the affair!

LETTERS TO THE EDITOR.

THE COLLECTION OF DEBTS BY DEBT-COLLECTORS.

To the Editor of The Medical Press and Circular.

Sir,—I ask space for a few remarks on the letter of " Medicus " and your comments on it. The collection of debts by debt-collectors is very common, and in most parts of the United Kingdom solicitors will generally undertake to collect debts at a percentage—usually 25 per cent.—relieving the client from all risk. But, of course, this is only done when the medical man places a number of debts in the hands of the same solicitor for collection. Against debt-collectors generally I have nothing to say; but I fancy what Judge Mulligan said was that when a debt-collector was not a solicitor he would not allow him to plead a cause in his Court. In this I think he was right, whatever the practice of his predecessor may have been. When a proceeding has to be taken in Court and the plaintiff cannot attend in person (or at all events, by his clerk, foreman, &c.), I think he should be required to employ a solicitor. The debt collector cannot be in a position to prove the debt unless he produces his employer's books, &c., for the purpose. That the doctor told him it was due and asked him to recover it is not evidence, and it would be unsafe to accept the evidence of a debt-collector, whose remuneration depends on his success, as to verbal admissions by the debtor unless there was some one to examine him.

But I apprehend that the debt-collector more frequently appears on the subsequent application for an instalment order or a committal order, though even here I am doubtful whether it ought to be permitted, He makes inquiries as to the debtor's means and knows much more about them than the creditor probably does; and he is the proper witness to show what instalment the man is able to pay and whether he should be committed to prison for non-payment. But we must here also distinguish between the man who conducts the case and the witnesses whom he calls. If nobody appears on behalf of the plaintiff except the debt-collector, whose function is merely to give evidence, would not the judge be justified in striking out the case on the ground that there was no appearance for the plaintiff?

What you say about a solicitor is correct enough, but the solicitor need not personally interview the debtor or write to him. He may employ a clerk for the purpose or even employ a debt-collector to do all the business except the conduct of the case in Court, and though his commission would be somewhat higher it would be worth paying, and I think solicitors would find it worth while to take up this class of business at a percentage.

But I do not think a doctor would gain much by trying to collect his debts by imprisonment—the favourite remedy, it would seem, of debt-collectors. If there were two doctors in the same locality one of whom imprisoned his debtors while the other did not, the latter would soon obtain all the business of the poorer people. And imprisonment for debt has now attained such dimensions and has created such an outcry that its days seem numbered. Certainly the public will not support any measure for making imprisonment cheaper and more expeditious than at present.

I am, Sir, yours truly,

B. L.

LAW FOR DRUGGISTS AND LAW FOR QUACKS.

To the Editor of The Medical Press and Circular.

Sir,—At the Mansion House on Friday last a firm of chemists was fined 40s. and 20s. costs for dispensing a prescription deficient in cinchona alkaloids to the extent of 55 per cent. of the amount that should have been present. The Magistrate wisely observed that it was a serious case because it was important to protect the public when they had prescriptions to be made up. In this case, the firm being one of repute, it is probable that the deficiency occurred owing to a mistake, and of this they, pleading guilty, accepted the responsibility. If the law has been made sufficient to reach comparatively trivial offences of this kind is it too much to ask that it should be extended to include the systematic and cruel frauds which are now allowed to be carried on with impunity by proprietors of quack medicines? Deducting the value of the small percentage of legitimate preparations paying stamp duty from the gross sum expended annually on "patent" medicines there remains a total of not less than £2,500,000 out of which the people are annually fleeced by vendors of quack nostrums. If this plunder represented merely pocket-picking it ought not to be allowed, much less ought such a trade be tolerated when associated with the infliction of suffering, injury and death. In previous communications I have explained and illustrated the cruelty of this form of quackery. My enquiries into the question continue, and they strengthen my opinion that the educated public and the legislature would not long tolerate the present abuses if once fully exposed. During the past few weeks, as visiting member of a hospital committee, I have given attention to cases of gastric ulcer. These have been patients of the domestic servant and dressmaker class. In a large proportion of instances I have found that these poor girls, often for prolonged periods before applying for medical advice have been relying upon one or other of the advertised cures for dyspepsia and stomach troubles; and have thus passed into a serious or dangerous condition (I have seen one fatal case of perforation within the past few weeks) which proper treatment might easily have averted. The bogus medical remedy trade is not only fraudulent, it is murderous; and this could be easily proved before the Royal Commission, which, let us hope, may be demanded and granted within the next few years.

I am, sir, yours truly,

Henry Sewill.

Cavendish Square, August 10th, 1907.

MILK AND TUBERCULOSIS.

To the Editor of the Medical Press and Circular.

Sir,—In view of the fact that Dr. Granville Bantock's opinions put forth during a discussion under the above heading in April last, must have influenced many of your readers and perhaps made some of them sceptical as to the necessity of the precautions against tuberculous infection insisted upon by the great majority of scientific sanitarians, it would be most interesting if Dr. Bantock would tell us whether he has read Dr. H. E. Armstrong's paper, published in the Medical Press of to-day (August 7th), and, if having read it, he adheres to the opinions he held four months ago. The tremendous practical importance of the issues involved seems to me to make it almost obligatory upon Dr. Bantock to justify his position, or to confess that it can no longer be maintained.

I am, Sir, yours truly,

A Family Doctor.

August 7th, 1907.

SPECIAL ARTICLE.

ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION.

Exeter, July 27th to August 3rd, 1907.

[From our Special Correspondent].

(*Conclusion.*)

The seventy-fifth Annual Meeting has come and gone and by one and all has been voted a great success. Scientific discourses, social functions, and renewals of friendships have each played a part; and if we mistake not the tastes and wishes of every type of visitor must have been thoroughly met. And now all that remains are pleasant memories and a plethora of papers which we imagine will more than meet the requirements of our contemporary, the *British Medical Journal*, during what even in the medical profession must be considered "the slack season."

Recollections and Reflections.

Our retrospect fills us with a general sense of satisfaction. The more successful a meeting is, however the more anxious should we be that its benefit and influence may be widespread and permanent. As compared with the conferences held by many other scientific and technical bodies, it must be admitted that the chief annual meeting of British medicos would not strike the onlooker as being what is most comprehensively described as "serious." There are many who deplore, and rightly so, the apparent lack of real interest in the consideration and discussion of those scientific principles and facts which should afford a sure and rational basis for the practice of the healing art. There certainly seems to be a danger that while the British Medical Association is undoubtedly attracting to its annual gatherings those who are keenly interested in what may, without discredit, be termed its "trade union" matters, those caring little for medico-ethical and medico-political discussions, but deeply concerned with scientific research and pathological progress, are quietly dropping their adherence and silently ceasing to take their part. Certainly in the recent meeting some of the best-known scientists and experts in medical science in this country were conspicuous by their absence. If this lapse of the scientific side of the annual meeting is to be allowed to continue, medical science will suffer incalculable loss. It is clear that there is need for special encouragement and thorough organisation. The work of the Sections requires to be arranged with greater care. Discussions should be planned with discrimination, and those specially qualified to take a useful part should be individually invited. Papers should be printed in advance. A Manual of Abstracts of all papers to be presented should be available a week before the meeting commences. It should be permissible for an author to arrange for the publication of his paper whenever he thinks fit. And perhaps most important of all, the scientific work should be collected and published in a special single number of the Association's *Journal* immediately after the meeting. These are not impossible suggestions, and if carried out they would go far to increase the real scientific value and general instructiveness of the meeting, without impairing its social enjoyments or robbing it of its justifiable picnicking.

THE PATHOLOGICAL COLLECTION.

Undoubtedly the most valuable feature of the Exeter Meeting was the very admirable Pathological Museum. Last week we were only able to refer to some few of the exhibits. Where every specimen presented points of interest it is extremely difficult to particularise. The catalogue provided was excellent, but it needed an index and lacked a conveniently arranged list of exhibitors.

A particularly helpful section was that portraying morbid affections of the skin. Mr. Jonathan Hutchinson sent a series of photographs and water-colour drawings illustrating various forms of cutaneous disease. Dr. David Walsh exhibited some particularly interesting photographs showing a frontal band area devoid of long hair or sparsely-haired or pencilled with a thin rim of hair, on one or both sides of the forehead, in cases of enlarged thyroid, and patients with potential Graves' disease and other somewhat allied affections. He also showed interesting water-colour drawings and photographs of generalised condylomata following primary infection of the left side of the upper lip.

Other valuable skin exhibits were made by Dr. P. S. Abrahams, Dr. B. H. Spilsbury, and the London School of Clinical Medicine. Dr. A. Moritz and Mr. P. B. Tubbs furnished a beautiful series of colour photographs of syphilitic and other lesions, taken by the Sanger-Shepherd process.

A feature of particular interest to teachers of morbid anatomy was Mr. G. Lenthal Cheatle's collection of giant sections, invaluable for the instruction of the student. Dr. William Hunter showed a number of specimens illustrating the hæmolytic, glossitic, gastric, and intestinal infective lesions of pernicious anæmia, which proved a valuable supplement to the discussion on this subject held in the section devoted to pathology.

It is quite impossible to mention anything like all the exhibitors, but we may note that preparations of particular interest were shown by Professor Walker Hall, Dr. F. W. Mott, Professor Symmers, Dr. J. Mitchell Clarke, Dr. T. Grainger Stewart, Dr. C. H. Miller, Professor G. A. Wright, Mr. B. G. A. Moynihan, and Mr. J. Bland-Sutton.

Many X-ray photographs of considerable clinical interest were exhibited by Dr. Reginald Morton, Mr. Rutherford Morison, Dr. J. Delpratt Harris, Dr. W. Cheyne Wilson, and Mr. E. W. H. Shenton. It should also be added that many specimens had been lent by the Royal Devon and Exeter Hospital; the Faculty of Medicine, University College, Bristol; the Royal Dental Hospital; the London School of Clinical Medicine, and other public bodies.

We have at least shown that the collection was a thoroughly representative one. Its usefulness would have been immeasurably increased if arrangements had been made whereby the various exhibitors could have demonstrated their particular specimens at set times. It is to be hoped that those responsible for the Museum at next year's meeting at Sheffield will make special arrangements for lantern and other desirable forms of practical demonstration of the more important specimens, instruments and photographs exhibited in the Pathological Museum.

We would suggest that those arranging for the collection at Sheffield would do well to endeavour to provide specimens and photographs of those particular deformities and diseases which directly or indirectly are connected with or in any way dependent on the very special forms of employment followed by such large numbers of the population in that great centre of industry.

GATHERINGS: OFFICIAL AND NON-OFFICIAL.

The Association's Annual Meeting furnishes opportunity for numerous and varied gatherings, some scientific, many social, both official and non-official. A broad-minded spirit of tolerance, sympathy and co-operation prevails, and such is to the general good.

On August 1st the Science and Education Committee of the National Temperance League held its annual breakfast, when some 160 members attended. The Mayor of Exeter (Mr. W. H. Reed) presided, and the president (Dr. Henry Davy), the Sheriff of Exeter (Dr. Ransom Pickard), the ex-president (Dr. R. A. Reeve, of Toronto), Sir John Moore, Mr. McAdam Eccles, Dr. A. T. Schofield, Dr. William Odell, Dr. T. N. Kelynack, Dr. Basil Price, and Mr. J. T. Rae (secretary of the National League) took part in the proceedings.

The same evening the Annual Dinner of the Association was held under the presidency of Dr. Henry Davy, when many toasts were enthusiastically honoured, and numerous eloquent speeches delivered.

Also on August 1st the Continental Anglo-American Medical Society held its annual luncheon, Professor W. Osler being in the chair, with a representative gathering of members and guests, including Dr. T. McCrae, of Baltimore, Dr. F. M. Sandwith, Dr. Newton Pitt, Dr. Ward Cousins, Dr. Galabin, Dr. Watson Williams, Dr. T. N. Kelynack, Dr. Herbert Tilley, Dr. Cholmeley, and many others.

The Irish Medical Schools' and Graduates' Association also gave a luncheon, and held their annual summer meeting.

Numerous garden parties, receptions, private luncheons, short tours, excursions, golfing and other pleasurable pursuits were crowded into Exeter's record week.

Among the many who have earned the sincere thanks of the Association and all its members, reference must be made to the genial and indefatigable President, Dr. Henry Davy, the alert and painstaking Hon. local secretaries, Mr. Russell Coombe, Dr. Clapp and Mr. Leonard Tosswill, and their numerous colleagues and helpers, the organisers of the Pathological Museum, Drs. Solly and Hawker. Indeed, to all our professional brethren in and about Exeter, and to the civic authorities and citizens generally, we offer on behalf of those who have enjoyed West Country hospitality, a very warm expression of appreciation and thanks.

THE ANNUAL EXHIBITION.

OWING to the necessarily condensed review of the recent Exhibition at Exeter, we were unable to deal as we could wish with certain preparations of particular interest to medical practitioners. Prominent amongst these the Nestlé's Anglo-Swiss Condensed Milk Co., Ltd., showed specimens of their Infants' Food, now well-known under the name of "Milo." This food has been produced in accordance with the strict physiological requirements of infant life.

A new Non-Irritant local anæsthetic "Novocain" was shown by the Saccharin Corporation, Ltd., of 165 Queen Victoria Street, E.C. This agent is being extensively employed for infiltration anæsthesia as it is much less toxic than Cocaine and can be used in conjunction with Adrenal products and is most effectual for lumbar anæsthetics, and in Ophthalmic, Dental and Naso-Laryngological work.

REVIEWS OF BOOKS.

THE MIND AND THE NERVOUS SYSTEM. (*a*)

This volume adds still another to the valuable series of works on general topics that have been given us by the well-known Zurich psychiatrist. As might have been expected, it is written in an interesting style and from a broad standpoint. It aims at presenting the rules of mental hygiene that should guide both the individual and society, and, as the author holds that for a full comprehension of the *rationale* of these rules, a fair knowledge of the mind and nervous system is essential, he has devoted two-thirds of the book to expounding the elements of normal and pathological psychology and physiology. The first section on psychology is written in a popular way that should increase its value to those medical men—unfortunately only too numerous in this country—who have had no training in this subject. The hygienic admonitions are sound throughout and largely follow the lines laid down in the author's larger work, "Die Sexuelle Frage."

ADAMS ON INFLAMMATION. (*b*)

We presume that many of our readers are already perfectly familiar with this monograph, which is in reality an extension of the article on Inflammation in Allbutt's well-known *System of Medicine*. It is, however, more complete and up-to-date. A fuller descriptive account of Wright's Opsonic theory is given. Likewise Bier's treatment of inflammation by induced hyperæmia has received attention. As regards the definition of the term inflammation, Adams leans to that put forward by Grawitz, who maintains that inflammation is the reaction of irritated and damaged tissues which still retain vitality. The manifestations of this process, under favourable conditions, are redness, swelling, heat and pain, to which Adams adds a fifth, viz., disturbance of function. Under unfavourable conditions all or nearly all of these symptoms may seem wanting, yet a minute examination of the tissues will show the same succession of changes.

The comparative pathology of inflammation is treated in an interesting manner, and a summary of the results so far reached at present is given. In the second part of this monograph the part played by the leucocytes in this process is very fully and clearly set forth. The chapters in this part of the book, describing the varieties and classification of the leucocytes, their functions and properties, and the theory of phagocytosis, are certainly, to our mind, the most valuable of all, and will be read with great advantage by every medical man who wishes to have a clearer conception of these matters. The author's remarks on the nature of the inflammatory exudation and the part played by the blood vessels and the nervous system in the process are clear and precise.

A very suggestive and helpful chapter is that dealing with the principles of treatment. The author shrewdly remarks that inflammation is a danger signal, but by no means necessarily a danger. He concludes by expressing his belief that it is by the study of cellular pathology in its strictest sense that the surest advance has been and is to be made in our knowledge of this the dominating process in disease. Professor Adams has been well advised in issuing in separate form this contribution to the modern pathology of inflammation. His observations shed a vast amount of light upon a somewhat obscure subject.

MEDICAL NEWS IN BRIEF.

Second International Congress of School Hygiene.

At the University of London Buildings on Monday, August 5th, at 3 p.m., the Earl of Crewe, Lord President of the Council, formally opened the Second International Congress of School Hygiene. On the previous Saturday an informal reception of the delegates had taken place at the University, and also two invitation receptions in the afternoon and evening respectively by Lady Londonderry, at Londonderry House, and by the Mayor of Westminster, at Caxton Hall. The Congress was very well attended, remarkably so when it is considered that a fortnight previously all the foreign invitations were in a state of chaos owing to the formalities that the Government offices insisted on with a determination worthy of a better cause. Most of the large and many of the smaller continental countries were represented, together with many of the Colonies and the United States, and a host of municipalities, large and small, in Great Britain. It may be taken as an indication of the world-wide interest exhibited in the Congress that even Siam thought well to appoint a representative. Lord Crewe, after conveying a special message from the King and a formal welcome from the Government, proceeded to deliver one of those happy speeches of which he is a past master and in which he threatens to rival his brilliant father-in-law. Lord Crewe had made himself well aware of the objects of the Congress and the methods by which those objects were to be pursued, and, speaking with ease and freedom, he created an excellent impression. No one who heard him was surprised that he had been chosen as the Government spokesman, though the absence of Mr. MacKenna, as Minister of Education, was much regretted. After Lord Crewe's speech, Lord Londonderry said a few agreeable words to show that the interest in the question in political circles is not confined to our side. Sir Lauder Brunton then delivered his presidential address. He, too, welcomed the delegates on behalf of the Executive of the Congress, and told them how much of the success of the undertaking was due to the personal influence and interest of that excellent diplomatist, the King. In an address, that was directed as much to the public as to the audience before him—for the great object of the Congress is to awaken general interest in the subject of School Hygiene—it was difficult for Sir Lauder to give those evidences of the originality of his genius which he has displayed in so many other fields, but his was a sound common-sense speech, and one eminently calculated to impress people with the idea that the question at issue is a practical one, and not an exotic off-shoot of the imagination or the silly creed of whimsical fanatics. After his speech, votes of thanks to himself and Lord Crewe having been passed with acclamation, a telegram was sent to the King expressing the thanks of the Congress for his interest. A conversazione was held in the University buildings in the evening, and on Tuesday the sections got to work. They met every day for papers, and such discussion as time permitted on the papers from 10 a.m. till 2 p.m., but their work was somewhat interfered with by the holding of a general discussion each day at noon on some set subject. On Tuesday this discussion centred on the methods of the first and subsequent medical examinations of school children; on Wednesday it concerned the lighting and ventilation of classrooms; on Thurs-

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(*a*) "L'Ame et le Systeme Nerveux: Hygiene et Pathologie." By Auguste Forel. 1906. Pp. 334. Paris: Steinheil. 5 francs.

(*b*) "Inflammation: an Introduction to the Study of Pathology." Being the Reprint (revised and enlarged) of an article in Professor Allbutt's "System of Medicine." By George Adams, M.A., M.D., F.R.S., sometime Fellow of Jesus College, Cambridge; Professor of Physiology, McGill University, Montreal. London: Macmillan and Co., Limited. 1907. 5s. net.

day, the school and its relation to tuberculosis, and on Friday, the last working day, on school-work in its relation to the duration of lessons, the sequence of subjects, at this season of the year. In the evenings, before and after dinner, there were lectures by eminent men on school subjects, and a number of excursions and visits to places of interest were organised by various committees and individuals. We hope to publish abstracts of some of the more interesting and important papers in the course of the next few weeks.

EXHIBITION OF BUILDINGS AND APPLIANCES.

Although the International Congress on School Hygiene has concluded its sittings, the exhibition of school building and furnishing appliances organised by the Royal Sanitary Institute will remain open at London University, South Kensington, until to-day. Taken collectively the exhibits brought together at South Kensington appear to present many essentials, from a hygienic point of view, for the equipment of elementary schools. International in its character, the exhibition shows in tangible form the movement for improving the hygienic conditions of schools now going on in so many countries. The features of the various systems favoured by countries other than our own in many cases are presented to the visitor by means of illustrations merely. In part, however, the exhibition consists of practical examples of school building and furnishing appliances. All departments of school hygiene are represented, ranging from building materials, floor and wall surfaces, water supply, drainage, sanitary appliances, warming, lighting, and ventilating, to the details of equipment, furnishing, teaching and technical appliances, gymnastic apparatus, and the accessories of the playground. To the appliances attempting to solve the problem of securing efficient ventilation without draughts one will naturally turn between much of the restlessness and inattention of which teachers complain arises from the enervating effects of stuffy classrooms. There is much in the exhibition to encourage hope of the problem, as applied to the schoolroom, being successfully solved. Improved types of desks, facilities for drying children's coats, shoes, and other apparel, and many more well-considered devices are shown for minimising the discomforts of school life and keeping children in health. In the grounds forms have been erected, among other structures, a handsome portable school pavilion of German make and design which, with the model and photographs of the Charlottenburg Forest School, presents many features that may profitably be studied.

Cholera Nostras in St. Petersburg.

ON August 9th there was a suspicious case of death at St. Petersburg. A *post mortem* examination has revealed the fact that death was due to cholera nostras. Telegrams from Samara, however, state that further fatal cases of cholera Asiatica have occurred there.

Status Lymphaticus Again.

AT Islington Coroner's Court on August 3rd, Mr. Schroder held an inquest on the body of William Percy Bishop, æt. 17, an indoor servant at Kensington, who died at the Great Northern Hospital. Bishop had a swelling in the upper part of the nose and went to the hospital to be operated upon. Dr. A. C. Brown, senior house surgeon, said that the operation took place, Dr. Rubra being the anæsthetist and Dr. Gay French, of St. Mary's the surgeon. The first incision had just been made in the nose when Bishop became white, and both operation and anæsthetic were stopped, but he died about two minutes later in spite of the efforts to revive him. The witness made a *post mortem* in the presence of Dr. Willcox, of St. Mary's, the Home Office expert. The *post mortem* revealed an enlarged thymus gland, a most unusual thing for a lad of 17. There was also an adenoid growth in the nose. Death was due to syncope caused by his condition from status lymphaticus. This condition could not possibly be diagnosed and could only be found in the present condition of medical knowledge after death. Dr. Rubra said he gave less than two drachms of chloroform and ether. The disease was receiving very careful medical attention at the present time. He had administered anæsthetic in over 10,000 cases. Dr. Brown, recalled, said status lymphaticus meant that certain glands secreted some fluids which acted as a poison, and evidence of this was found in several organs. There had been a very similar case some time ago in the West-end, that of a young baronet. A verdict of "death by misadventure" was returned.

An Unfortunate Accident.

AN inquest was held in Sheffield on August 12th on Mrs. Elizabeth Carlisle, the widow of a Sheffield ivory cutter, whose death was due to carbolic acid poisoning. The deceased's doctor, it was said, had several times taken to the house a small quantity of carbolic acid for use as a disinfectant. One morning, being in a hurry, he did not prepare the solution, but left the acid behind for Mrs. Carlisle's sister to mix later. Before she did so, however, the servant gave Mrs. Carlisle her medicine and inadvertently added a teaspoonful of the poison. A verdict of "Accidental death" was returned.

General Midwives' Board.

DURING the August sittings of the Examiners one hundred and thirty-one candidates were successful. Of these, the largest number were trained at the Maternity Charity, Plaistow; the General Lying-in Hospital, Queen Charlotte's Hospital, and the Salvation Army Maternity Hospital were also large contributors. Other candidates had undergone training at the Rotunda, Dublin, the Edinburgh Royal Maternity Hospital, Brighton Hospital for Women, etc., whilst a considerable number had attended the classes of Dr. St. Aubyn-Farrer and Dr. A. B. Calder.

The Alltymynydd Sanatorium.

A MEETING of the executive of the West Wales branch of the National Society for the Prevention of Consumption was held at the Carmarthen Guildhall on August 2nd, Mr. E. Trubshaw, of Llanelly, presiding. Dr. Douglas Reid, of Tenby, referring to the main object of the meeting—the consideration of the steps which should be taken to provide funds for the sanatorium at Alltymynydd, near Llanybyther—suggested that, in order to maintain the 20 beds there, the counties of Carmarthen, Cardigan, and Pembroke, should be divided into 20 districts, each of which should be responsible for a bed. He presented two alternatives, that there should be eight or ten districts in Carmarthenshire, six or five in Cardiganshire, and six or five in Pembrokeshire. The yields of the counties in the above order, if each person gave a penny a year, would be £67 10s., or £54 10s. per annum, with a population of 130,000, £43 or £52 with a population of 62,000, and £62 10s. or £75 with a population of 90,000. If possible, patients should pay a small weekly sum. In the event of fewer districts for each county, a few beds could be kept for the paying patients. A district which did not collect the sum required should not have the nomination to a bed. After a discussion, the executive decided to issue circulars to all likely subscribers in the West Wales counties.

University of London—The Rogers Prize.

UNDER the will of the late Dr. Nathaniel Rogers, the Senate offer a prize of £100, open for competition to all members of the medical profession in the United Kingdom, for the best essay or dissertation setting forth the results of original investigations made by the candidate on any medical pathological subject during the preceding two years. Candidates will be permitted to present papers published during the preceding year as the dissertation. The essay or dissertation, by preference typewritten or printed, must be sent in not later than May 1st, 1908, addressed to the Clerk of Committees, University of London, South Kensington.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Treatment of Syphilis by Intramuscular Injections of Mercury.—Lambkin (*R.A.M.C. Journ.*, July, 1907) suggests a new preparation for use in this method of treatment. Hitherto the difficulty has been to find a vehicle which would remain aseptic, and at the same time be soluble in the organism. Glycerine, gumwater, olive oil, vaseline, oil of vaseline, and lanoline have all been used to hold the mercury in suspension, but each and all of them are open to considerable objections. For the past eighteen months Lambkin has been using palmatin as a vehicle. This is a neutral fat derived from palm oil, and having the same chemical composition as the palmatin of the human body. The advantages claimed for it are that it is non-toxic and non-irritant; it is as easily oxidised as the other compounds of human fat; being a normal constituent of the human organism it is easily saponified and soluble therein, and does not enter the circulation as a foreign body; as a vehicle it makes a more homogeneous preparation for injection than any other, and its melting point can be raised and lowered with the greatest facility. In order to obviate the pain which is a serious objection to the injections, especially when calomel is used, Lambkin suggests the use of a combination of pure creosote and camphor. The formulæ of the two mercurial creams which Lambkin is now using are as follows:—Hydrargyrum pur., 10 grammes; creo-camph., 20 cc.; palmatin basis to 100 cc.; 10 m. equals metallic mercury one grain. Calomel, 5 grammes; creo-camph, 20 cc.; palmatin basis to 100 cc. 10 m. equals one half grain of calomel. Each cream has a melting point of 37°C. The creo-camph. consists of equal parts of absolute creosote and camphoric acid. Each of the creams can now be obtained from Messrs. Oppenheimer in aseptules graduated to hold a maximum dose of 15 m.

K.

Acute Dilatation of the Stomach.—Telford (*The Med. Chronicle*, July, 1907) records a case of this rare condition which ended fatally in three days. The patient, a boy, æt. 16 years, was suddenly seized with severe colicky pains in the upper part of the abdomen. These pains persisted for about thirty-six hours, when he began to vomit large quantities of reddish yellow fluid. The vomiting persisted, and there was no motion of the bowels, although some medicine had been taken. The boy left his bed with the intention of going to stool, and on his return was found to be in a very collapsed state, and died in a very few minutes. The patient had not been seen by a medical man before his death. At the *post-mortem* examination the stomach was found to be very considerably distended, and contained six pints of fluid of a similar nature to that which was vomited before death. The stomach walls were deeply congested, and on them there were many submucous hæmorrhages. The first and second parts of the duodenum were involved in the distension, and the pyloric ring was scarcely perceptible. The remaining part of the intestines were collapsed and empty. The distension of the duodenum ceased abruptly at the point where the gut is crossed by the mesenteric vessels, but Telford was unable to assure himself that the gut had been constricted by these vessels. It was ascertained that the boy had had six similar attacks at various intervals during the three days which preceded his death.

K.

The Influence of Heredity in the Prognosis of Phthisis.—Von Ruck (*Amer. Journ. Med. Sciences*, August, 1907) investigates the commonly received opinion of the unfavourable influence of tuberculous ancestors on the prognosis in cases of phthisis. It has recently been suggested that the old idea is not correct, and that the children of tuberculous ancestors enjoy a partial immunity from tuberculous infection; and even when infection does take place the prognosis is better than in those not so protected. Von Ruck gives the figures of Turban and Weicker in support of this hypothesis, as well as the records of the last 1,415 cases treated at the Winyah Sanatorium. Of these patients 31.11 per cent. showed a history of tuberculous ancestry. Of those discharged cured, and of those discharged improved, 32.16 and 31.5 per cent. respectively had an hereditary taint, while of those who failed to improve or got worse only 25.13 per cent. gave such a history. The numbers are not sufficiently large to warrant any dogmatic conclusions, but the indications point in favour of the view that the mere fact of a tuberculous family history need not, in any individual case, diminish the patient's chance of recovery.

K.

The Cause of Sea-Sickness.—Lund (*Practitioner*, August, 1907) investigates the cause of this condition, and comes to the conclusion that the stimulus which causes the vomiting reaches the brain through the auditory nerves. He does not believe that the organ of vision transmits the impulse as blind people are found to suffer from sea-sickness to a greater extent than those who can see. Thus sixty per cent. of the pupils of the Liverpool School for the Blind suffer from the complaint, and another twenty per cent. are uncomfortable when taking a sea trip from Liverpool if the sea is at all rough. He has found, however, that deaf mutes never suffer from sea-sickness, nor do they experience that sensation in the stomach once described as a momentary displacement of the viscera to which most of us are liable when descending in a lift. Lund concludes that there is some mechanism in the auditory organ, possibly the system of semicircular canals, which is directly affected by the oscillations of a vessel at sea, and which acts as a stimulus to the vomiting centre. It is conceivable that these sudden movements may create in the endolymph in the semicircular canals a condensation or rarefaction, or both alternately, thereby altering the pressure on the nerve endings and causing a direct stimulus to vomit.

K.

The Mongolian Pigment Spots.—Brennemann (*Archives of Pediatrics*, June, 1907) deals with the occurrence of these spots in the infants of the American negroes. In the sacral or sacro-gluteal region of nearly all Mongolian children are found one or more well-defined distinctly blue or greyish-blue spots varying in size from that of a small coin to that of an expanded hand. These spots may be found in 97 to 98 per cent. of such children up to two and a half years of age, and in 10 to 12 per cent. after four years, and only rarely after the fifth year. For some time the condition was looked on as a racial characteristic of the Mongolian, but Adachi has shown that it it also occurs, though more rarely in the children of other races. Brennemann has examined forty coloured children under one year of age, and has found the spots well marked in thirty-five of them. In older children it is impossible in the majority of cases to decide whether a spot is still present or not; but in the younger children there is no such difficulty Brennemann is inclined to look on this pigmentation. as a persistence in a rudimentary form of what was once a more wide-spread and functional layer of pigment such as exists in certain monkeys; but why the remnant should favour the sacral and adjoining regions when there is no such tendency in monkeys, he is unable to explain. It is, however, obvious that we can no longer consider these spots as exclusive race characteristics. K.

Kuhn's Lung Suction Mask for Hyperæmia Treatment of the Lungs.—Kuhn's (*Mun. Med. Woch.*, 1907) mask consists of a celluloid cap to cover mouth and nose, which renders inspiration difficult, while expiration proceeds unhindered. This induces hyperæmia in the air passages and lungs. Kuhn's experience at Von Leyden's clinic has been decidedly favourable, and Stolzenburg also reports great benefit from the use of the mask in 24 cases of pulmonary tuberculosis. It not only relieves the patients subjectively, but exerts a favourable influence on the morbid process. He adds that it is perfectly harmless. Kuhn found in 16 patients that the number of reds increased by a million after one hour's use of the mask, while the whites increased by one thousand. He has used the mask further in five cases of fibrinous pneumonia and the disease assumed a very mild course. In a case of severe asthma, the patient, a woman, has been free from attacks for the first time for years since she has been systematically using the mask. D.

Acid Intoxication, a Factor in Disease.—Talbot (*Med. Record*, June, 1907), in investigating the cause of erosion of the teeth, has collected tests of the total acidity of the urine of a large number of patients. He believes that excessive acidity of the urine is associated with interstitial gingivitis and is an indication of faulty metabolism. D.

The Diagnosis of Pyelonephritis Based on the Abnormal Retention and the Delayed Excretion of Methylene Blue.—Beer (*Journal of the American Med. Assoc.*, June 8th, 1907), in a preliminary communication, publishes the histories of two cases which seem to point to a new diagnostic sign of the involvement in suppuration of the kidney parenchyma. In the first case, the patient discharged methylene blue stained pus in the urine at intervals up to two and three-fourth years after the last administration of the drug. The second patient had pyelonephritis (verified by nephrotomy) and recurrent discharges of methylene blue stained pus over a month after the last administration of the drug. He produced pyelonephritis in a dog and then for several days administered methylene blue. The kidney was removed two days later, and after treatment with oxidizing agents, showed multiple bluish-grey foci throughout its substance. He summarises his conclusions derived from the facts so far as follows: (1) There is no differential diagnostic sign between simple pyelitis and pyelonephritis. (2) Pyuria from the upper urinary tract may be due to either of these conditions. (3) By use of the above described methylene blue test it would seem that a differential diagnosis may be made. (4) Methylene blue is deposited in the parenchymatous abscesses and may be stored in these for years. (5) A late discharge of methylene blue, bound to the pus, is indicative of the rupture of such parenchymatous abscesses into the pelvis of the kidney, and is consequently diagnostic of pyelonephritis. D.

The Examination of the Heart in the Trendelenburg Position.—The examination of the heart with the pelvis elevated possesses, according to Stern (*Mun. Med. Woch.*, 1907) the following advantages: (1) The percussion of the right border becomes easier; (2) doubtful systolic murmur at the apex becomes more evident or disappears; (3) the presystolic murmur in mitral regurgitation complicated with stenosis is more readily detected. D.

The Action of Atoxyl upon Syphilis.—Uhlenhuth, Hoffman, and Rorcher (*Deut. Med. Woch.*, 1907) report a series of eleven cases of syphilis treated by atoxyl and conclude that it has an unmistakable good effect when used in sufficiently large doses; it is especially beneficial in the malignant forms. They injected intramuscularly ten cases with a 10 per cent. solution, and one with a 15 per cent. solution. The injections were of .2 to .6 gm. every two days at first, later every three days. It caused no local disturbance. It makes a very important addition to our means of combating syphilis in those cases which have an idiosyncrasy against the mercury and iodide treatment. D.

New Investigation on the Dorsal Foot Reflex.—Lissman (*Mun. Med. Woch.*, 1907). The dorsal foot reflex consists in the movement of the toes on tapping the outer part of the dorsum of the foot with a percussion hammer. Normally the toes (excepting the great toe) are extended, but in disease plantar flexion may occur. Lissman confirms the observations of the two describers of the reflex, finding it positive (*i.e.*, plantar flexion) only in cases with positive Babinski's sign, and absent altogether in anterior poliomyelitis. He also found in infancy the reflex positive in all cases with positive Babinski. The significance of this sign is therefore identical with that of Babinski's, indicating (except in infants) disturbance of conduction in the pyramidal tract. D.

Tuberculosis and Heredity.—With a view of testing the doctrine of the hereditary transmission of tuberculosis, Hagen (*Johns Hopkins Hospital Bulletin*, August, 1907) has examined the condition of certain families, of each of which two or more members were attending the Phipps Dispensary. In all 83 families were examined, containing a total of 534 individuals. Of these 254, or 47 per cent. were tuberculous, and 13 were suspicious. In 62 per cent. of the tuberculous cases there was no tuberculosis in the immediate ancestors, 43 per cent. of those exposed to marital infection became infected, while only 38 per cent. of those exposed to parental infection developed the disease. Only three persons of tuberculous stock developed the disease when not in association with their families. There were eleven well marked instances of house infection. In fifteen instances one or both parents had the disease, while the children were entirely well. Hagen's conclusions, therefore, are entirely opposed to the doctrine of hereditary transmission. Moreover, as his families were selected definitely on account of the large number of infections occurring in each, one would expect in them, if anywhere, to find evidence in favour of hereditary influence. On the other hand, he believes that "infection acquired by long continued and intimate association plays the only *role* in the transmission of pulmonary tuberculosis." R.

Manchester University.

At the Graduation ceremony last week the following were recipients of degrees:—

Degree of Master of Science.—Harry Andrew, George Henry Kenyon, Frederick William Dyson Marshall, and Charles Watson Moore.

Degree of Master of Surgery.—Arthur Ralph Thompson.

Degrees of Bachelor of Medicine and Bachelor of Surgery.—Thomas Wingate Todd, first-class honours; John Arnold Fairer, second-class honours; Frank Hartley, second-class honours; Robert Lakin, second-class honours; John Webster Pride, George William Bury, Harold Coppock, Daniel Irving Dakeyne, James Fleming Dow, Frederick Hall, Vasantrio Dinanath Madgavkar, Peter Moran, Wilfrid Nightingale, Alice Oberdorfer, George Rainford, Robert Robertson, Douglas Rodger, Elsie Marsh Royle, Vincent Southwell, Gilbert Bertram Warburton, Henry Whitehead, and Norman Reginald Williamson.

NOTICES TO CORRESPONDENTS, &c.

☛ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

ESPERANTO.—The address of the Esperanto headquarters is Arundel Street, Strand, W.C. You had better apply to the Secretary, as he will probably be able to say whether any medical books are published in Esperanto. We do not know of any.

GYM.—The founder of the system known as "Swedish Gymnastics" was one Henrik Ling, a university fencing Master at Lund, Sweden. He founded the Central Gymnastic Institute, and published a large book on "General Principles of Gymnastics." Ling was born in 1776, and died 1834. He was succeeded and his methods developed by Gabriel Branting (1799-1881) and his own son, Hjalmar Ling (1820-1886).

THE GREAT PEPPERMINT CURE.

Readers who are unacquainted with the recondite properties of peppermint will be surprised to learn, from the following extract from the *Financial News*, the amount of commercial value they represent:—

"W. E. Woods Great Peppermint Cure Company.—July 30. £20,000 (£1). To adopt agreements (1) with the W. E. Woods Great Peppermint Cure Company, Limited (registered in New Zealand), and W. E. Woods; (2) with H. T. Tompsitt and S. Fripp; and (3) with Spottiswoode, Dixon and Hunting, Limited, to pay to the said New Zealand Company royalties on sales by this company of "Peppermint Cure," and to carry on the business of proprietors and manufacturers of and dealers in patent medicines, etc. No initial public issue. First directors (not less than three nor more than five): J. P. Humphris, W. E. Wood, and R. St. J. Hughes. The said New Zealand Company may, while holding £5,000 shares, appoint a permanent director, the said W. E. Wood being its first nominee. Qualification (except permanent director), 250 shares, £100 each per annum. 57 Moorgate Street, E.C."

H. N. T.—The routine administration of potassium iodide in cases where excess of mercury has been taken is not unattended with danger, as by releasing the metal from the tissues it passes into the circulation, and may considerably aggravate the symptoms.

ETHICAL.—We cannot undertake to recommend particular disinfectants, as such advice is out of our province, but you may take it that the advertisements of such as are admitted to the columns of reputable medical papers are all pretty efficient, and the makers will gladly supply you with literature concerning them.

Vacancies.

Bailbrook House, Bath.—Medical Superintendent. Salary, £450 per annum. with board for self and wife if married, furnished quarters, laundry, attendance. Applications to Herbert Coates, Secretary, 49 Broad Street, Bristol.

North Lonsdale Hospital, Barrow-in-Furness.—House Surgeon. Salary, £100 per annum. with board and lodging. Applications to the Secretary, North Lonsdale Hospital, Barrow-in-Furness.

Egyptian Government.—Kasr El Ainy Hospital.—Resident Medical Officer. Salary, £250 a year, with quarters, servants, washing, coal, and light. Applications to The Director-General, Public Health Department, Cairo.

Egyptian Government.—Ministry of Education.—School of Medicine, Cairo.—Assistant to the Professor of Pathology. Salary, £E.320 per annum. Applications to The Director, Government School of Medicine, Cairo, Egypt.

Royal South Hants and Southampton Hospital.—House Physician. Salary, £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher Hall, Secretary.

Loughborough and District General Hospital and Dispensary.—Resident House Surgeon. Salary, £100 a year, with furnished rooms, attendance, board, and washing. Applications to Thos. J. Webb, Secretary.

Glasgow District Asylum, Woodilee, Lenzie.—Assistant Medical Officer. Salary, £135 per annum, with board, lodging, washing, etc. Applications to the Medical Superintendent.

Worcester County and City Asylum.—Assistant Medical Officer. Salary, £140 per annum. Applications to Superintendent Powick, Worcester.

Devon County Asylum.—Assistant Medical Officer. Salary, £140 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent, Exminster.

Rochdale Infirmary.—House Surgeon. Salary, £100 per annum, with board, residence, and laundry. Applications to Henry Booth, Secretary, 58a Yorkshire Street, Rochdale.

The Royal Victoria Hospital, Dover.—House Surgeon. Salary, £100 a year, with board, lodging, and washing. Applications to the Hon. Secretary, Arthur B. Elwin, Esq., 2 Castle Street, Dover.

York County Hospital.—House Surgeon. Salary, £100 per annum, with board, residence, and washing. Applications to Fredk. Neden, Secretary and Manager.

County Asylum, Prestwich, Manchester.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, furnished apartments, and washing. Applications to the Medical Superintendent.

Royal Albert Hospital, Devonport.—Resident Medical Officer. Salary, £100 per annum, with apartments, board, fuel and lights, and laundry. Applications to the Chairman of the Selection Committee at the Hospital.

County Borough of Northampton.—Medical Officer of Health. Salary, £400 per annum. Applications to Herbert Hankinson, Town Clerk, Guildhall, Northampton.

Appointments.

BENTHALL, ALBERT, F.R.C.P.Edin., M.R.C.S.Eng., under the Workmen's Compensation Act, 1906, a Medical Referee for Circuits Nos. 40 and 42.

BURTON, C. F., M.R.C.S.Eng., L.S.A., by the Shipping Federation, Examining Officer of Seamen at Whitby under the Compensation Act.

DAVIDSON, THOMAS, M.B.Edin., House Surgeon at the Stockton and Thornaby Hospital.

DE SOUZA, D. H., M.B., B.S., B.Sc.Lond., Demonstrator in Physiology at the University of Sheffield.

GOUGH, A., M.B., Ch.B.Leeds, House Surgeon at the General Infirmary, Leeds.

GREENWOOD, F. G., M.B.Cantab., House Physician at the General Infirmary, Leeds.

RODRIQUES, N. JOSEPH, L.R.C.P. and S.Edin., Assistant House and Visiting Surgeon to the Stockport Infirmary.

TINLEY, W. E. F., M.D.Durh., Certifying Surgeon under the Factory and Workshop Act in the Whitby District.

WALKER, M. G. L., M.B., Ch.B.Leeds, Junior Resident Ophthalmic Officer at the General Infirmary, Leeds.

Births.

COLTART.—On August 4th, at 714 Fulham Road, London, the wife of Guy H. Coltart, M.B.Lond., M.R.C.S., L.R.C.P., of twins (son and daughter).

COOPER.—On August 6th, at 87 Great Portland Street, the wife o A. Tanner Cooper, M.R.C.S., L.R.C.P., of a son.

Marriages.

MUNRO—MACLEOD.—On August 7th, at St. James's Church, Westend, Southampton, Ranald Martin Cunliffe Munro, B.A., Barrister-at-Law, of Queen Anne's Mansions, son of the late Major-General A. A. Munro, Bengal Staff Corps, of Woodside, Frant, to Norma, daughter of Colonel Kenneth MacLeod, M.D., LL.D., Indian Medical Service (retired), Honorary Physician to H.M. the King, and of Mrs. MacLeod, Duncaple, Westend.

PHILIP—KYD.—On August 8th, at Rosebank, Aberdeen, James Farquhar Philip, M.D., Ealing, son of the late Rev. William Marshall Philip, M.A., minister of Skene, to Isabella Caithness, daughter of Thomas Kyd, resident manager at Aberdeen of the Northern Assurance Company.

RAMSDEN-WOOD—WILKINSON.—On August 6th, at Cookshire Quebec, Norris, eldest son of W. E. Ramsden-Wood, M.D., of Waterside, Uplyme, Devon, to Eva Millicent only child of J Wilkinson. Esq., of Cookshire, Quebec.

Deaths.

BENNETT.—On August 8th, at Bimpert House, Shaftesbury, Elizabeth Louisa, widow of W. H. R. Bennett, M.R.C.S., L.R.C.P.

BUNTING.—On August 7th, at Earlham, Torquay, Agnes Selina (Chaplin). the wife of James Bunting, M.R.C.S.Eng.

KALLEY.—On August 8th, at Campo Verde. Edinburgh, Sarah Poulton Kalley, beloved wife of the late Robert Reid Kalley, M.D., Madeira and Brazil.

KENNARD.—On August 2nd, at Bloomfield House, South Lyncombe, Bath, Thomas Atherton Kennard, M.R.C.S., (late of Kempsey, Worcester), in his 74th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, AUG. 21, 1907. No. 8

NOTES AND COMMENTS.

The Medical Referee Begins.

THE value of the medical referee under the Workmen's Compensation Act, 1906, was demonstrated signally before the end of the first month that the measure came into force, by an incident in the Birmingham County Court. A workman had been injured in the head at some bedstead works, and been paid compensation; but after some time the firm thought him fit to resume his duties. The medical man consulted by the workman's solicitor did not take the view of the firm's medical man, and the question was put by the court to the medical referee. This gentleman, after examination, certified that the workman's pain and giddiness were not attributable to the accident, but to his being out of work and indulging in excess of alcohol. Under these circumstances the judge naturally stopped the payments. Before the employment of referees such a case as this would have been fought out in Court, and besides the waste of time and money, it is just as likely as not that the judge would have given a wrong decision. The whole question in these cases turns on the medical aspect of the case, and no one but a medical man is able properly to judge of that. We venture to expect that if the medical referees are freely employed at first by the County Courts, the bogus claimant and the adventurous solicitor will find the Act is not such a soft thing for them as they anticipate. Under the old Acts, as is commonly known, malingering and fictitious injuries were commonplace scandals, which had only too much chance of encouragement if they went to court.

A Valuable Knee.

WITH a little observation and ingenuity it was quite possible for a sharp workman who preferred half wages and nothing to do to full work and full wages, to make a comfortable living out of some old injury. All that was necessary was to obtain employment, work for a week or two, and then have an "accident" to the old place. The employer was then bound to pay till he got tired. A notable story of an alleged professional claimant was told at West Ham Police Court the other day, when a man was charged with obtaining money by false pretences from a confectioner. It was said that this man had a very profitable knee, which every six months or so was served up in a claim for damages against some local tradesman for having a defective cellar-flap or pavement-light which tripped up the owner of the knee. A tobacconist gave evidence of parting with £33, a caterer £6 in cash, the doctor's fees, and £1 in goods, and a tailor £30 in about 18 months, all for the same knee and for similar accidents. All medical men know the difficulty of resisting a claim where there is a definite lesion involved, even though convinced that it has little or no relation to the accident. It may now reasonably be hoped that in workmen's compensation cases, at any rate, the medical referee will be able to put a stop to much misplaced ingenuity.

Hounslow and Out-patients.

THE dislike and distrust of the out-patient department is growing, if not on every hand, at least in many quarters, and the battles that are being fought against hospital abuse certainly centre round that institution as the worst offender. At Hounslow the medical men attached to the hospital appear to have taken the decided ground that the out-patient department is more abused than legitimately used, and consequently they have intimated that they propose to withdraw giving their services to it at the end of the year. The subscribers who are privileged to give away four out-patient letters in return for a guinea subscription wish to continue the department, and it will be interesting to see if any workable arrangement can be arrived at. There seems to be no doubt that the subscribers have been exceedingly indiscreet in the way they have given their letters away, and have thereby not only deprived medical men of their fees, but have by their action directly discouraged thrift. Dr. Gordon, of Hounslow, asserted in a recent interview that there is absolutely no need for an out-patient department, and that the medical men are determined that it shall cease, at any rate, as far as abuse is concerned. The subscriber who uses his hospital letter as a cheap form of patronage, and not as a public trust, is, alas! only too well known, and it is high time that he should be brought to realise his responsibilities.

Lord Curzon and the Plague.

AT the end of last month a letter written by Lord Curzon to one of those correspondents who ask such convenient questions of public men was published in a Chester paper and republished in the *Times*. In this letter the ex-Viceroy pilloried certain statements made by a Socialist orator that the British administration in India is responsible for the plague, and the Indian Government only exerted "puny efforts" to combat the scourge, as "grossly mendacious and ignorant." His Lordship asserts that the Government have conducted an "unrelenting campaign" for nine years, but that their efforts had been confronted throughout with appalling ignorance and superstition, and that the question often resolves itself into one, not of scientific method, but of administrative expediency. A very pertinent reply to this claim was made a few days subsequently in the columns of the *Times* by Dr. F. Fremantle, a late Plague Medical Officer in the Punjaub, who pointed out that though the Indian Government certainly undertook measures of some magnitude to combat plague in the early stages of the epidemic, they left undone the most important thing of all, namely, the scientific investigation of the cause of plague-spread. The Government have now got together some investigators—a small band—to try to work out this vital point, but it is obvious that this should have been the first step, and not the last. Public health measures are so absolutely dependent on exact scientific knowledge that it is often more than useless to carry out heroic campaigns against the most patent dangers, unless accurate information as to their remedy is previously obtained.

Judge Mulligan and Debt Collecting.

In our last issue we published a letter from a correspondent, "B. L.," on the subject of Judge Mulligan and debt collecting. Much of what he therein said is both true and to the point, and we would most heartily associate ourselves with him in his remarks about imprisonment. In theory, imprisonment for debt in the case of those able but not willing to pay is, of course, justifiable; in practice, it is one of the worst blots on our civilisation. Those who, like ourselves, have studied the question, must we believe hold the very idea in horror, so inequitably and so cruelly does the system operate in practice. The point which we would criticise in his letter, however, is where he speaks of the appearance of the debt collector in court. As our information goes, the debt collector is, to all intents and purposes, the principal in the matter—he proves the debt by means of producing a written acknowledgment of liability from the debtor. A County Court judge has discretion to hear whom he likes, but he can refuse to hear anyone except a party in person or his legal representative. Now, it has been found in petty debt collecting that by a simplification of machinery, sanctioned by custom, the small debtor gets off much more easily than by employing the full legal process, and the creditor is much more likely to come by his own. If abuse were shown we should be prepared to modify our views, but as we read the case his Honour is insisting on the pedantic employment of the full legal machinery, and thereby stultifying the ends of justice.

LEADING ARTICLES.

SOME INDUSTRIAL DANGERS.

The Annual Report of the Chief Inspector of Factories and Workshops, which was noticed in these columns some months since, contains a great deal of matter of medical and of medico-social interest. Now that the responsibility of the employer is fully recognised, the community is to a great extent relieved of the cost of supporting the sick and wounded of the industrial army. It is only by an efficient system of skilled inspection that the workmen will ensure a proper protection and employers will be able to reduce accident and trade diseases to a minimum. The Report of the Chief Inspector, Dr. Whitelegge, for the year 1906, bears testimony to the thoroughness with which an enormous mass of detailed information has been collected and dealt with. There were in all 255,189 works inspected, employing in factories 4,150,000 persons, in workshops 700,000 and in laundries 100,000. The Certifying Surgeons, for medical reasons, rejected no less than 3,257 children and young persons desirous of obtaining employment in factories, and 2,016 for non-medical reasons. These figures afford some idea of the scope of the operations of the Factory Department which has during the year added to its Registers no less than 31,240 factories and workshops. There were 632 cases of lead poisoning notified in the year under report, as against 592 in 1905, 1,058 in 1900, and 1,258 in 1899. In connection with claims under the Workmen's Compensation Act under the heading "encephalopathy," in the cases of plumbism it is interesting to note eleven cases of epilepsy and coma, three of mental derangement, and seven of optic neuritis. The striking observation occurs that in one factory the occurrence of seventeen cases within the last four years led to an examination of 87 of the workers, of whom six showed a trace of a blue line, nine were pale or anæmic, one had definite partial paralysis of the right wrist and one weakness of the fingers. Of sixteen cases in the printing trade eight occurred in compositors, three in stereotypers, two in machine operators, and one each in a type caster, a store room hand, and a general worker. The blue line on the gums, we are told, is rarely found among printers. In thirty cases lead poisoning was returned as the direct or indirect cause of death. There are some ten or eleven thousand persons engaged in the tobacco, cigar and cigarette industry, but out of that number careful enquiry revealed only two cases of nicotine poisoning, two of amblyopia, one of gastralgia, and one of smoker's heart. Clearly, then, it would be impossible to consider that particular industry as an unhealthy one. The laundry industry presents some interesting statistics. In the year 1901 91,086 persons were employed, of whom 50,547 were engaged in steam laundries. During the year 1906 there were 301 accidents reported to the certifying surgeons, as against 288 in 1902. Some interesting facts are recorded in the Report of the Electrical Inspector. There were eight fatal electrical accidents in factories, engineering works, and so on. Four of these occurred under the heading of faulty apparatus, and it is significantly noted that many burns of that class are due to the circuits being too heavily fused, thus allowing heavy currents to flow under short circuit conditions. In one instance a man took hold of a leaky lamp fitting which he was repairing and received 230 volts through his body to earth, whilst standing upon some iron plates. A youth, in a cellar, the floor of which was wet with pickling brine, took hold of the pedestal of a leaky electrical fan with one hand, while he turned on the switch with the other. He received a current of 200 volts, alternating supply, through his body to the ground. He was unable to drop the fan until the current was cut off, when he immediately dropped to the ground and shortly afterwards expired. In another case an electrician was fitting up a temporary light, when he took hold of some wires in a joint which he had neglected to "tape up", and receiving a shock to earth with 200 volts was killed. "He probably," remarks the Inspector, "held the popular but erroneous idea that with such a low pressure there is no danger." In another instance a youth was killed whilst trimming an arc lamp which he had lowered to within a few feet of the ground. The switch was faulty and although the lamp was extinguished, the circuit was broken at one pole only, one blade of the switch remaining in contact with the other pole. The lamp was, therefore, alive at 200 volts above earth, the system being 3-phase, 350 volts per phase. The unfortunate youth was unable to release his hold of the lamp until switched off by another person, when he fell to the ground. This Report is in many ways full of interest to the public in general and may be commended to the notice of medical men in particular, for they will find therein a vast amount of information likely to be of great professional value.

PUBLIC HEALTH IN INDIA.

It is high time that the enormous waste of human life in our great Indian Dependency should engage the serious attention of the British Legislature. The responsibilities of Empire do not end with the simple establishment of law and order under the influence of a mild military despotism. It is impossible to disregard the moral obligation that is attached to the dominant British race in maintaining a good standard of public health in India. There is no lack of fearless and well informed criticism upon the point. Major Ronald Ross, a clear-headed authority on all aspects of epidemic disease, has spoken out his mind repeatedly in a way that no governors of a civilised country can permanently disregard. In a recent communication he sums up the chief points of the indictment against the Indian Government for its attitude with regard to the plague. The facts he brings forward are as follows:—(1) Although the disease had been raging in Hong-kong for two years before it appeared in Bombay, the Indian Government did not make adequate preparations to exclude it, or to detect and combat it on its arrival in India; (2) when it arrived in 1906 it was allowed to remain undetected for months; (3) when it was detected at last it was met only with the vacillating counsels of the unprepared; (4) although great efforts to check it have undoubtedly been made since then, it is questionable whether they have always been organized in the best possible manner. From this it will be seen that Major Ross accuses the Indian Government of want of wisdom and of inertia rather than of actual indifference to the plague. The root of the matter, it is to be feared, is to be found in the lack of a proper public health organisation throughout India. Even in our military administration sundry matters are on a far from satisfactory footing, an assertion that can be readily proved by a study of the Indian Army Medical Reports. In dealing with the native populations of the East it is, of course, necessary to realise that one is confronted with the vices of ignorance, superstition, and suspicion, but that is no excuse for defective sanitary administration. Major Ross makes a palpable hit when he points out that India has not done so well as other countries in dealing with malaria during the last ten years, that is to say, during the administration of Lord Curzon, who, in sanitary matters, is one of the strongest supporters of the policy and the administration of the Indian Government, yet malaria causes more sickness than plague does, and it can be dealt with medically without injuring the susceptibilities of the natives. It is open to Lord Curzon to state what serious practical measures were taken by him during his administration of India to check the ravages of malaria. Vague generalisations are not a sufficient answer in reply to the categorical thrusts of so doughty a knight as Major Ronald Ross.

CURRENT TOPICS.

A Prescription for Childlessness.

The *Herald of Health* is a journal primarily devoted to the cult of the vegetarian. Incidentally, however, it deals with a wide range of subjects, but appears to be mainly of the "anti" type of faith. A page at the end is devoted to "Hygienic Answers to Correspondents," for non-urgent cases and for those unable to pay fees. The Editor declines to advise the use of Wallace's specifics, for information as to which readers are referred to that gentleman's work on "Physianthropy." We gather that the writer in question is an unqualified practitioner and we further infer that he has certain original views upon vaccination, as on the same page a book is advertised under the title of "The necessity of small pox as an eradicator of organic disease." The Editor, himself, deals with the case of a correspondent who has "strained a gland in the groin during a foot race which has since suppurated." To meet this medically unknown pathological condition he advises a hot sitz bath 20 minutes nightly, or hot compresses for one hour, and that the feet be kept in hot water half an hour each night: salad oil and rest during the day. The attitude of the man who regards suppurating glands in the groin as non-urgent is somewhat startling, whatever view may be taken of his treatment of the following case, headed, "Is my wife well enough to bear a child?" The applicant having benefited by previous advice in many troubles would like his domestic life to be blessed by offspring. In his answer the editor gives detailed directions for "three good, slowly eaten meals daily, two of them consisting of bread made on Wallace lines or got from the P.R. (?) bakery, and fresh ripe or stewed fruit. The third meal is to consist of two new laid eggs, a heaped teaspoonful of conservatively and thoroughly cooked pulse, three ounces of ground nut, or three or four ounces of home-made Wallace cheese. The foregoing are to be eked out with various vegetables. 15 or 16 hours are to be devoted daily to exercise, domestic duties, visiting, reading, and so on. As soon as that can be done happily without being more fatigued than will enable you to enjoy a good night's rest and awake refreshed in the morning, and maintain your health otherwise, then you may prepare your hearts for the introduction of a little one into your home." We fancy that plain food and plenty of exercise is a somewhat old fashioned prescription for sterility, apart from bread and food "on Wallace lines." By the way Wallace appears to be a baker who advertises extensively.

State Medical Attendance.

THE recent plea of Dr. Newsholme in support of the provision of medical attendance by the State deserves careful consideration. It may be that he is simply thinking ahead of the times, and that the proposal which seems so revolutionary to-day may become the established fact of a few generations hence. For when the matter is looked into a little more closely it is evident that the principle has been already adopted in various directions by a State that is not given to headlong advances. For instance, the Poor Law of the United Kingdom recognises the right of any pauper citizen to receive medical attention at the expense of the community. Further, for the protection of the citizen, both individually and collectively, the legislature has decreed that vaccination shall be available free of cost to everyone. The most striking instance, however, to be found is in the public infectious hospitals which are open freely to all classes and are a charge upon the community. An extension of such services to the general public would, therefore, simply involve the development of existing machinery. Were the medical profession to discontinue the vast amount of gratuitous services rendered to hospital patients and to private persons from whom no payment is to be expected, a huge additional charge would at once be thrust upon the Poor Law, whose work is to a great extent anticipated by the contributions of the public and the labour of medical men. Sooner or later the State will probably have to protect or help to support the general practitioners.

Medical Papers and the Lay Press.

ABOUT six months ago a spirited protest was made from several quarters against the practice of certain medical journals sending round to the lay press advance proofs of original communications made to their columns. The objection seems to have been so far successful that the particular journal most concerned has not since been quoted in the manner objected to; but of late original papers in other of our contemporaries have been freely and accurately reproduced in some daily papers, with the author's name so prominently displayed as to suggest that the editors have not been unaided in the process of selection. Now though certain medical addresses, such as the introductory lectures at the medical schools, the Harveian oration, and so on, are usually reported in the lay press, these addresses are generally given with an eye to the diffusion among the public of ascertained medical truths, or medical views on socio-medical subjects. They are not given to glorify the lecturer's clinical skill or professional acumen. In the case of the papers spoken of above, it appears to be different. The authors' work as related in the particular communications referred to represent simply their own views, which may or may not be sound. Such papers are published in medical journals so that the profession may have an opportunity of forming a judgment on them, and till such judgment has been passed it is obviously most undesirable that sensational abstracts from the original paper should be published with startling headlines in the lay journals. The names of authors whose papers so appear are not likely to smell the more sweetly in the nostrils of the profession, and in their own interests and that of the dignity of the profession they would do well to put a stop to this unhappy practice.

The Hospital Building Craze.

THE proceedings of the Metropolitan Hospital Sunday Fund do not always meet with our unqualified approval. Indeed, we have on various occasions criticised freely their policy, for instance in their neglect of small hospitals, and in their arbitrary and inconsistent methods in enforcing amalgamation schemes. With their recent condemnation of the building craze on the part of London medical charities, however, we find ourselves in perfect accord. There are said to be about a thousand unoccupied beds in London hospitals at the present moment, but in spite of that fact, quite a number of those institutions are moving heaven and earth to forward fresh building schemes. Sir Edmund Currie has taken the matter vigorously in hand, and it is to be hoped that his efforts will give pause to not a few of those unbusinesslike schemes. A standing monument of "how not to do it" is afforded by St. Mary's Hospital, Paddington, which has erected a gorgeous new building at vast expense, but is unable to do more than keep the beds in the old premises occupied. It would be much more to the benefit of the community to insist upon accommodation being provided in outlying districts, instead of permitting a few large central hospitals to divert huge sums to their own aggrandisement. It is to be hoped that the hospital funds will exact their influence in bringing the medical charities into some sort of system as regards their present reckless expenditure upon extensions, regardless of debt and of deficiences of income. At the same time, Sir Edmund Currie may be trusted to look well into the individual cases of the smaller hospitals before coming to any decision as to their claims to public support.

The New Public Health Act.

ALTHOUGH the Public Health Bill which has lately passed the Commons is mainly consolidating, yet there are various additions of some importance.

There is little doubt that the Bill, pretty much as it now stands, will pass into law. The eighteen clauses dealing with infectious diseases are specially interesting. Among them are powers given to the medical officer to examine school children, to require a list of scholars when one is suffering from infectious disease, provisions as to library books, power to require dairymen to furnish a list of sources of supply, dairymen to notify infectious diseases existing among their servants, power to local authority to pay expenses of persons in hospital, and to provide nursing attendance. If a dairyman is called upon to state the sources from which his milk is obtained, he will be rewarded with the modest sum of sixpence; and if he fail to comply with the requisition he will be subject to a fine of £5 and a daily penalty not exceeding £2. The provision as to furnishing the names and addresses of all scholars applies to all schools, and the sixpenny scale of payment to the head of the school is the same as for dairymen, but the fine for non-compliance is only £2, and there is no continuing penalty. The local authority may provide nurses for persons suffering from infectious disease who cannot be removed to hospital, and may pay such reasonable sums for the services of the nurses as they think fit. But the operation of this, as of all the other sections, depends upon the initiative of the local authority.

A Permanent International School Hygiene Council.

AN important development of the late Congress on School Hygiene is the formation of a permanent International Council on the same subject. This Council is to consist of the president of the past two congresses and the president of the next congress, together with nine other members yet to be elected, but of whom three are to be natives of this country, three of the country where the next congress will be held, and three members from other lands. The Council is not to meet for discussion in the ordinary way, but will deal with subjects that arise by correspondence, and will be empowered to make decisions on urgent matters. The questions that they will consider almost at once are how medical inspection of schools can best be carried out with the maximum of efficiency and the minimum of cost; how far the laws of health can best be imparted to the rising generation, so that they may learn how to take care of themselves and those dependent on them; what are the best systems of physical training for both sexes at various ages; and how the feeding of improperly-nourished children shall be carried out without developing pauperism and with due regard to those on whom the cost falls. No one will deny the value of such functions nor be disposed to withhold admiration from the gentlemen who are sufficiently courageous to undertake them, but it may seriously be doubted whether the questions the Council propose to themselves are what may be termed international. They seem to us to be more strictly national, and to raise issues that each country must work out for itself according to its own customs, habits, and means. Still there are many points of general interest, such as the setting up of normal standards of vision for children of various ages, and the prevention of epidemics by school agency, in which the experience and knowledge of experts in different countries will be of high value, and we wish the new body every success in its honourable self-imposed mission.

The L.G.B. and Medical Salaries.

IT is highly unfortunate when the profession is striving to raise the quality and prestige of its members that a department like the Local Government Board, which is so intimately connected with medical work, should do anything to belittle medical men or to lower their remuneration. An almost incomprehensible instance of such action is reported from Edmonton. The Board of Guardians for that district lately advertised for an assistant medical officer for the workhouse, requiring a "whole-time" man, and offering a salary of £180 a year, without extra allowance. As a matter of fact, only two replies were received, neither presumably suitable, for the Guardians decided to advertise again, offering a higher salary, to wit, £220. This salary was disallowed by the Local Government Board, who no doubt were fully informed of all the contingent circumstances. With every desire that proper economy should be observed in local administration, it strikes us as preposterous that the Guardians are forbidden to offer a salary which will attract a suitable candidate for the purpose of looking after the comfort and well-being of sick paupers, and still more so that the whole time of a medical man is a post not very attractive from the professional point of view, should be rated at not worth four guineas a week. The Local Government Board must surely be aware that if it wishes for adequate medical care to be bestowed on the poor, it must be prepared to allow market rates of payment, and we hesitate to believe that they wish anything less than skilled service placed at the disposal of old and infirm paupers.

PERSONAL.

SURGEON-GENERAL BOMFORD, Director-General of the Indian Medical Service, has been granted the Distinguished Service award.

WE regret to learn that Major Fullerton, of the Indian Medical Service, has died at Lucknow from blood poisoning, contracted while performing an operation with a pricked finger.

THE Chief Inspector of Factories gives notice that Dr. W. Carroll and Dr. J. H. Thomas have been appointed certifying surgeons for the Rathdowney district of Queen's County, and the Market Harborough district of the County of Leicester respectively.

SIR DONALD CURRIE, G.C.M.G., has given a further sum of £2,000 to the Queen's College, Belfast, in order to complete the sum of £5,000 which is required for the recreation grounds of the College. This gift makes a total of £22,000 which Sir Donald Currie has given to the College.

IT is reported that plague has broken out at San Francisco, and that an active campaign has been instituted in New York against rats in ships coming from South America. The port authorities of the United Kingdom will doubtless follow suit.

A CLINICAL LECTURE

ON

THE CONSEQUENCES AND TREATMENT OF LACERATION OF THE FEMALE PERINEUM.

R. J. KINKEAD, M.D.Dub., L.R.C.S.I.,

Professor of Obstetrics in Queen's College, Galway; Physician and Gynæcologist to the Galway Hospital.

GENTLEMEN.—I have selected for discussion with you to-day the consequences of laceration of the perineum in the female. I do not propose to deal with the risks resulting therefrom during the puerperal period, except to tell you that in every case of laceration in labour, the rent, be it big or little, should be sutured at once; and to quote for you from Dr. MacNaughton Jones' "Diseases of Women," words of wisdom you should imprint on your memories:

"Assuredly if practitioners only recognised the ills, immediate and remote, which follow lacerated perineum, we should less frequently hear of secondary operations. . . . Take it all in all I believe there is not in the entire range of gynæcological practice a point more necessary to insist on than the early closure of the perineal wound after parturition. This caution pertains rather to midwifery than to gynæcology, but it has such an important bearing on the future happiness and comfort of the woman when labour has been long forgotten, that it warrants the stress laid upon it."

In the majority of cases union follows immediate suturing.

In relaxation, and in ununited laceration of the perineum, an enlarged and gaping vaginal orifice results, which by interfering with, or incapacitating from, sexual intercourse affects domestic happiness and tends to promote infidelity. Remedial operation is as imperatively called for in the interests of marital felicity and morality, as it is in those of the woman's physical well-being and her restoration to active useful life.

To understand how disasters arise from its injury, and how they are to be remedied, you must have a clear comprehension of what the perineum is, and of the functions it performs.

For about its upper two-thirds the posterior vaginal wall is contiguous to the rectum, at the lower third, however, the rectum bends back to the anal orifice, while the vagina continues its forward curve, in the space thus formed between the lower end of the rectum and vagina, a triangular mass, composed of strong elastic connective tissue, the perineal body, is interposed, with its base resting on the intersection of four muscles, over which lies the skin.

This skin surface, which you can see, is about one and a half inches long by two in breadth, and extends from the level of the posterior commissure of the vulva to that of the anterior margin of the anus, is usually spoken of as the perineum; and under the mistaken notion that the perineum was only this and nothing more, operations have been recommended and performed for its restoration utterly inefficient, and which had better have been left undone.

"The Transverse perineal muscles cross the base of the perineal body horizontally, between the vaginal outlet and anal orifice, each one fusing with its fellow on the opposite side; a number of the muscular bundles diverge from the horizontal fibres, anteriorly and posteriorly, at angles of about 30°, to fuse in front with the constrictor vaginæ, and behind with the sphincter ani."

When I speak of the perineum, I mean this composite structure of connective tissue, muscles and skin.

The origin of these muscles, the transverse perineal from the tuberosities of the ischium, the constrictor vaginæ from the pubes, and the sphincter ani from the coccyx, being at a higher level than that at which they pass under, and fuse together beneath the perineal body act like C springs, and with every contraction lift that body upwards; while the levator ani arising higher up within the pelvis, passing downwards and backwards to its rectal attachments, not only lifts the rectum, but draws it, the perineal body and the vagina, forwards towards the pubes.

Thus the anterior and posterior walls of the vagina are kept in close contact, and the vagina is maintained as a solid column—the chief factor in supporting the uterus and preventing prolapse.

Lacerations almost invariably occur in the middle line, and run vertically back; they vary in size from an unimportant tear of the fourchette, or, a more serious one, down to or through the sphincter, to a huge rent into the anus, laying open the rectum for one or more inches, and making the vagina and rectum a common cloaca. In the graver cases the perineal body is split vertically, the fusion of the transverse perineals is rent asunder, and the sphincter ani torn across; through the contraction of these muscles, the lacerated tissues are pulled apart. Hence—as I believe, the late Mr. Lawson Tait was the first to point out—while the original tear ran in the anterio-posterior plane of the body the rent heals in the bilateral plane, as shown by the transverse position of the cicatrix.

Thus the vagina is transformed from its normal condition of a solid column, with its posterior wall in apposition with, and supporting, the anterior, into an open tube with an enlarged and gaping vaginal outlet.

When the rectum is laid open, according to the extent of the laceration, there is more or less incontinence of fæces, unfitting the woman for domestic or social life, and rendering her existence miserable.

Whether involving the integrity of the rectal wall or not, the usual consequence of grave laceration is prolapse and procidentia of the vagina and uterus.

Time does not permit me to tell you to-day all the symptoms, and attending ills of rectocele, cystocele and "falling down of the womb."

Suffice it to say they injure the health, give rise to rectal and bladder troubles, and incapacitate the woman from work.

The uterus normally lies diagonally in the pelvis, on the bladder, the cervix pointing backwards. The anterior wall of the vagina is attached to the base of the bladder by cellular tissue, and lower down, more closely to the urethra. When owing to relaxation, or deformity resulting from laceration of the perineum, the support afforded to the anterior vaginal wall is removed, more especially in women, unable to lead restful luxurious lives, but obliged to be on foot most of the day, or to earn their bread by laborious occupations, procidentia may occur suddenly. Usually, however, the process is gradual: under the influence of abdominal pressure and the weight of the urine in the bladder, the anterior wall sags down, and its lower portion containing the urethra protrudes at the vaginal orifice: this is only the first step, and is followed by a descent of more of the vaginal wall with the base of the bladder.

When this occurs the bladder cannot be completely emptied, a pouch being formed below the internal orifice of the urethra. The tendency to descent is now aggravated by the weight of the urine contained in the pouch, and by the force directed downwards into it when the bladder contracts to empty itself.

Bearing in mind that the vagina is attached to the cervix uteri, you will understand that as the anterior wall descends its upper part must pull on the cervical extremity of the uterus, and tend to drag it down, at the same time tilting the body of the uterus up.

Sometimes, however, this does not happen, the uterus remains antiverted, and as an antiverted uterus cannot prolapse, the cervix after a time yields to the strain, and becomes so elongated that we find it and the everted vagina protruded from the vulva, while the body of the uterus remains at its normal elevation in the pelvis.

More frequently the pull brings the uterus first into a vertical position, which facilitates its prolapse, and as it sinks an increased protrusion of both vaginal walls takes place; under the influence of abdominal pressure and the increased vaginal drag, the uterus falls further and further down, changing its direction until it lies in the axis of the outlet, and finally is extruded between the woman's thighs covered by the everted vagina.

As in this lecture I am only dealing with laceration of the perineum, I shall not discuss the other causes of, nor attempt to enumerate the mechanical expedients adopted, and the operations devised to alleviate or cure, prolapse and procidentia uteri.

The object of treatment of laceration should be the cure of its immediate consequences and the prevention of those resulting from neglect. For both, operation is essential, and should be performed as soon as the parts have healed.

Operations for the restoration of the perineum are nearly as numerous as the leaves in Vallombrosa. For my own part I prefer and invariably perform that of the late Mr. Lawson Tait: I have done it in all sorts of cases, with some modifications in dealing with the rent, when the recto-vaginal septum was involved, and am satisfied with the results, which I have found stand the stress of subsequent labours.

I quote for you Mr. Lawson Tait's description of the operation in cases where the laceration does not lay open the rectum.

"Having the folds of the buttocks pulled firmly apart so that the cicatrix is put on the stretch, I enter the point of the scissors at its extreme end on one side and, keeping strictly to its line, I run through to its other extremity. The incision is about ⅜ of an inch deep, and it forms two flaps—a rectal and vaginal. From each end of the incision it is carried forward into the tissues of each labium for about an inch, and again backwards for about ⅓ of an inch.

"The vaginal flap is held upwards (the patient being on her back), and the rectal flap being turned downwards, and the angles of the flaps being pulled by forceps diagonally upward and inward and downward and inward respectively.

"The sides thus become straight, and the wound takes the form of a parallelogram.

"By means of a stout-handled, well-curved needle the silkworm gut sutures are entered on one side about ⅛ of an inch within the margin of the wound (so as not to include the skin). They are buried deep in the tissues, and then the needle is made to emerge so as to miss the upper angle of the wound. The needle again enters at same distance from the angle and emerges ⅛ of an inch from the skin margin on the other side.

"By thus missing the upper or deep angle of the wound, the two great and divided masses of the old perineum, which lie in the parallelogram, respectively bounded by the points of entry and emergence of the needles, are accurately adapted.

"The rectal and vaginal flaps respectively point into the rectum and vagina, and like an old-fashioned flap valve, prevents noxious material entering the wound.

"The resulting mass of the perineum is amazingly large, and union is almost inevitable.

"The resulting cicatrix is absolutely linear, and so resembles the natural raphe, that in three or four months after the operation it is quite impossible to determine from the appearance of the parts that the perineum has ever been injured, for there are no stitch hole marks left to tell the story. I leave the stitches in for three or four weeks, and take care that the rectum and vagina are washed out daily.

"My operation really restores the perineum to its original form and dimension, and makes the patient as good as new.

"That this is so can be seen at once on considering that the transverse incision, in splitting the septum with its small exteniores, fore and aft, really reproduces the original perineal tear, which runs in the anterio-posterior plane of the body.

"The rent has healed in the bilateral plane of the body, as shown by the transverse position of the white line of the cicatrix. The new incision is made in transverse line, but the wound is closed at right angles to it.

"Then as the whole structure of the perineum is opened up and the parts formerly continuous are re-united absolutely in their original position, the torn ends of the sphincters are thus again continuous, and complete functional activity is restored.

"The peculiar method of inserting the sutures is essential to this means, for in this way only can the old relative of parts be restored."

If the recto-vaginal septum is laid open the operation is more complicated.

When the rent extends high up, the upper portion is not affected by the transverse pull of the muscles, and the tear assumes the shape of an inverted V with the apex above.

I split the septum to about an eighth of an inch above the angle of the tear, thus making four flaps—two vaginal and two rectal. The corners of the vaginal flaps are first caught and held up with forceps, and beginning above the angle of the tear, on the raw or rectal aspects the margins of the flaps are sewn together by a continuous suture of fine catgut, the needle being entered a little more than an eighth of an inch from the edge of the tear, and brought out close to, but not through it; it is then entered close to the edge on the other side, and emerges an eighth of an inch from it, care being taken not to perforate the vagina in passing the suture.

By this procedure surfaces an eighth of an inch wide, for the entire length of the tear, are brought into apposition, and the edges project into the vagina.

The rectal flaps on their vaginal aspect are then sutured in the same way, the comparatively broad mass of tissue brought together, and the closely-approximated edges projecting into the rectum, prevent any leakage therefrom into the wound.

The operation is then completed as before described.

I performed this operation with complete success last session in the County Galway Hospital in a case of extreme laceration extending up to Douglas's pouch.

This affection affords an example of the adage that the exception proves the rule; for we meet with cases of ununited laceration in which, with only a narrow portion of tissue between the vulva and anus, the woman seems not a pin's worth the worse. You may ask, should such case be operated on? I unhesitatingly reply they ought to be. The unfortunate possessor of a relaxed vaginal outlet or lacerated perineum is always in a state of danger, for while some may end their days without evil ensuing, in others from sudden strain, over-exertion, ill health, or other causes, disasters may result, and it is much simpler, more certain, and far easier, to prevent prolapse or procidentia than to remedy them once they have occurred.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by G. F. Still, M.A., M.D., F.R.C.P., Professor of Diseases of Children, King's College, London. Subject; "Infantile Diarrhœa."*

University College, London—School Hygiene.

A new course on School Hygiene, including lectures, demonstrations, and practical work, has been arranged to begin on October 16th, at University College. The Course will be given by Professor Henry Kenwood and Dr. H. Meredith Richards. It is designed to meet the requirements of school teachers, school lecturers, and those qualifying for school inspectorships and for school medical officers. A certificate of proficiency will be granted to those who qualify themselves.

ORIGINAL PAPERS.

PHAGOCYTOSIS & BACTERICIDAL ACTION. (a)

G. DEAN, M.B., C.M.Aber.,
Bacteriologist, Lister Institute of Preventive Medicine, London, &c.

Metchnikoff's theory of Phagocytosis is one of the greatest conceptions of modern biology. Combated at the outset by many of the leading pathologists of the time it has steadily gained ground, till now it is almost universally accepted.

It would be impossible to consider as adequate any description of infection, inflammation or immunity which omitted to give a due consideration to phagocytosis. While upholding the cell as the most important factor, Metchnikoff and his pupils could not long overlook the part played by the body fluids in the process of protection.

The work of Nuttall, Pfeiffer and others showed that the blood serum alone in the absence of cells had powerful bactericidal properties. The evidence in favour of this bactericidal action of the serum was so conclusive, and the fundamental experiments were so easily confirmed that the phagocytic theory was for some time overshadowed by the humoral. It soon appeared, however, that bactericidal effects of serum due to bacteriolytic action could not be demonstrated in the case of all organisms, *e.g.*, staphylococcus and streptococcus. According to Metchnikoff this bactericidal action did not play an important part in the living body under normal conditions. The blood plasma did not behave like the serum in this respect. The bactericidal substance had its origin in the phagocyte, and was set free by its death, during the process of clotting, or in the case of the living animal when phagolysis was produced by an excessive dose of bacilli injected experimentally. The bacteriolysis, therefore, was a secondary phenomenon of phagolysis.

On the other hand, in the case of immune animals, there were present in the blood substances which played an important function in aiding phagocytosis. These latter bodies are thermostable and unlike the substance previously referred to, the cytase or complement, which is readily destroyed by a temperature of 56°c.

Two forms of activity have been attributed by Metchnikoff and his pupils to those thermostable bodies. (1) A stimulin action; (2) a fixative action.

When a highly virulent organism is injected into a normal animal the leucocytes do not show any great disposition to attack the invader. The virulent organism tends to repel, or at least, not to attract the phagocyte; in other words, the bacillus has a negative chemiotaxis for the leucocyte. In an immunised animal, on the other hand, no sooner does the virulent organism find an entrance into the body than the leucocytes crowd to the site of infection, surround the invaders, and if the immunity is sufficient, englobe and destroy the enemy. That this property is due to something in the plasma or serum, and not to properties of the leucocytes acquired by education or otherwise, is shown by injecting some of the blood plasma or serum of the immune animal into a normal animal, in which case the leucocytes of the new animal thus passively immunised behave in the same manner as did those of the actively immunised animal. Substances which thus heighten the activity of the leucocytes Metchnikoff has designated "stimulins."

(a) Introduction of Discussion, British Medical Association meeting, Exeter, 1907.

In the second view, the serum is conceived as acting primarily, not on the leucocyte, but rather on the microbe, on which a change is produced, so that it no longer repels, but rather attracts the phagocyte; in other words, its negative chemiotaxis is converted into a positive chemiotaxis.

It would be impossible here to detail even the chief of the earlier contributions on the subject, a brief *résumé* of some of these has been already published by the writer in a former paper.

Interest in these questions had been re-awakened, especially in this country, by the work of Wright and Douglas, who, by a modification of a method devised by Leishman, had made a number of observations emphasising the importance of the serum in the mechanism of phagocytosis, and showing for the first time in an unequivocal manner the fact that normal serum as compared with other fluids, such as normal salt solution, had a powerful action in preparing the microbes for phagocytosis in cases where no bacteriolytic or bactercidal action was apparent.

The substance in serum which had this action, was found to be thermolabile, and was designated by them "opsonin."

In the case of furunculosis, tuberculosis, &c., Wright and Douglas showed that the injection of vaccines made from the appropriate micro-organisms was followed by an increase in the opsonins. The phagocytic method introduced by them attracted many workers, and the fundamental experiment has been repeated and confirmed by many. Much critical investigation will be necessary, however, before the establishment of the claims made as to the value of the method for clinical use.

The nature of the opsonins, their relation to substances previously described and named by others, the value of the method from the clinical standpoint, and the experimental error involved have already been, and must still for some time be, a subject of enquiry for many observers. Such subjects as these would be appropriate for the present discussion.

He then proceeded to review the recent work on these lines, and detailed a number of his own experiments bearing on the subject.

The bulk of the evidence as sifted from the literature and deduced from his own experiments along with those of others, drove him to the conclusion that the opsononising action was due to the effect produced by two bodies acting together: the one thermostable, known variously as the fixateur substance, sensibilisatrice, amboceptor, &c., is the essential substance. It alone is capable of opsonising, but its activity is greatly increased by the presence of free complement, known also as "Cytase," "Alexin," &c. The amboceptor is present in only small quantities in normal serum, hence the apparent thermolability of the "opsonin" in normal serum, whereas in an immune serum the amboceptor plays a predominant part and though heating results in a loss of activity, this is only partial. In both cases the loss is due to the destruction of the complement.

The reason why one type of organism such as the typhoid bacillus is bacteriolysed by the action of these substances, whereas another such as the staphylococcus, though prepared for phagocytosis, without any bacteriolytic effect being apparent, probably arises not from the fundamental difference in the method of action of the serum, or in the substances in the serum which produce the effects, but from a difference in the physical nature of the microbe itself. The experimental basis for these views was fully discussed.

INDICATIONS FOR OPERATION IN CASES OF INTRA-CRANIAL TUMOUR. (a)

J. S. RISIEN RUSSELL, M.D., Edin., F.R.C.P. Lond.

Physician, University College Hospital, London. &c.

DR. RISIEN RUSSELL introduced the Discussion by referring to the importance of diagnosis in which connection he called attention to the possibility of confusing cerebral tumour with disseminate sclerosis, general paralysis of the insane, migraine ophthalmoplégique, and certain other affections, including hysteria, which, in his experience, had been operated upon in mistake for intra-cranial tumour, and emphasised the important points which serve to distinguish these affections from cerebral tumour. In dealing with the conditions under which operation is to be recommended he drew a distinction between cases in which it was advocated with a view to effecting a cure, and those in which it was undertaken merely as a palliative measure. Before advising operation in the first class it was essential that the exact localisation of the tumour should be determined, and this not only in so far as to be able to say that it occupied the brain, as opposed to the cerebellum for instance, but also which cerebral or cerebellar hemisphere, and which part of the hemisphere, was involved. Tumours situated near the surface of the cerebrum, and those occupying one lateral lobe of the cerebellum or the lateral recess, were the most favourable for operation, while those in the mesencephalon, the middle lobe of the cerebellum, notably the anterior portion, and the deeper parts of the cerebral hemispheres, might be regarded as inaccessible from the point of view of the possibility of cure. The probable nature of the growth had an important bearing on the question under consideration, there being always a chance of recurrence in the case of malignant growths, so that they offer less chance of cure than do simple tumours. The prognosis was also less favourable in cases in which diffuse or multiple tumours were present than when the neoplasm was circumscribed or single. In this connection Dr. Russell referred to syphilitic tumours. He laid stress upon the fact that surgical intervention was necessary in a considerable proportion of these cases, and his experience had proved that it was useless to waste valuable time in pushing antisyphilitic treatment when the symptoms were not yielding to mercury and iodide of potassium. Another important consideration was the degree of risk to life from the operation and its immediate effects, and with regard to this he hoped to hear the opinions of some of the surgeons who were taking part in the Discussion. Where other considerations justified the belief that a tumour which had been diagnosed and accurately localised could be successfully reached and removed by the surgeon, he considered that the risk of life ought not to deter the physician from recommending operation. In this connection the amount of permanent defect likely to result from the operation should be taken into consideration. In cases where paralysis was to be expected, and death from the effects of the tumour the only alternative, one could not reasonably hesitate to advise operation, but it was a much more difficult problem when permanent aphasia was likely to result. The majority of people must of necessity hesitate, if indeed they could ever bring themselves to accept an alternative to which death seemed almost preferable. With regard to palliative operations there could be no question as to the beneficial effects of trephining for the relief of abnormal intra-cranial pressure. He emphasised the importance of this procedure as a means of arresting optic neuritis and of saving sight, though it must not be supposed that every patient suffering from optic neuritis had an intra-cranial tumour, or that optic neuritis of toxic origin would be relieved by trephining. In conclusion he referred to the circumstances under which lumbar puncture could be substituted for trephining. It should, however, be regarded only as a palliative measure, which could not be expected to permanently relieve the symptoms. It was valuable as a means of relieving urgent symptoms of pressure, when to wait for a surgeon to trephine would be to allow the patient to die, or when the patient's condition was too bad to permit of the major operation. He also called attention to the importance of the part played by lumbar puncture in the diagnosis of general paralysis of the insane. He considered that it was a procedure which should be employed for diagnostic purposes and the relief of urgent symptoms in cases of intra-cranial tumour, but which should not be regarded as likely to permanently relieve symptoms, prolong life, or effect a cure. In quoting cases in illustration of his remarks he referred to a typical example, in which the diagnosis was easy and the operation successful; another in which, although the operation was successful, the diagnosis was less accurate, in that an intra-medullary cyst of the cerebellum was discovered instead of a tumour external to the organ; a third, in which the diagnosis of tumour seemed certain, and yet this was not discovered at operation, although the patient subsequently recovered from the symptoms which suggested the diagnosis which led to the operation. A fourth case showed how cerebral thrombosis might be readily mistaken for tumour; while in a fifth case, where disseminated sclerosis accounted for the clinical picture, the earlier symptoms strongly suggested a tumour of the mid-brain.

(a) Abstract of Paper to introduce Discussion in the Section o Surgery, British Medical Association, Exeter, 1907.

MR. HARCOURT COATES, M.R.C.S., L.R.C.P., aged 54, of the Hill, Laverstock, Salisbury, consulting surgeon to the Salisbury Infirmary, surgeon to the police, and Medical Officer of Health at Salisbury, has left estate valued at £41,486. He left the residue of his property (about £20,000) to the Salisbury Infirmary, upon trust, to build a wing, or surgical ward, to be known as the "Harcourt and Maud Coates Ward."

DISINFECTION CONSIDERED FROM A MEDICAL, CHEMICAL, AND BACTERIOLOGICAL STANDPOINT (a)

BY S. RIDEAL, D.Sc., F.I.C.

IN opening the discussion on disinfection in its medical, chemical, and bacteriological aspects, I do not think I can do better than very briefly summarise the more recent work on the subject. I have the more pleasure in doing this, and I think you will have more interest, on account of the decided advances that have been made during the last few years in our knowledge of disinfection, of the preparation of disinfectants, and of the proper modes of testing them. However, there are still many points requiring further investigation, and these I shall have also to indicate.

Firstly as to the disinfection itself, the growth of knowledge in the public has to a certain extent eliminated the old idea that it solely consisted in removing smells or disguising them by other odours. An examination of the various disinfectants placed in the hands of our sanitary authorities shows that the majority are several times more potent than carbolic acid, on which formerly such great reliance was placed. Similarly with disinfecting appliances great advances have been made. Dependence is not now so largely placed on aerial disinfection—the air-borne theory being to a large extent exploded—but it is combined with other methods, such as spraying and the removal of infected material as far as possible; in fact, in certain cases the necessity of destruction or steam disinfection of clothes, &c., has been generally recognised; and in place of the disinfection being either inefficient or equivalent to destruction, steam disinfectors can now be obtained which ensure not only safe and adequate heating, but also the complete displacement of the air, which is such an essential factor.

The fallacy of attempting to arrive at or control the germicidal efficiency of disinfectants from chemical analyses has often been pointed out, but on the other hand the hopeless divergency of bacteriological tests was not helpful. The desirability of standardising the test culture in every experiment was emphasized in 1896 by Pearmain and Moor ("Applied Bacteriology," p. 288): "In order, therefore, to obtain some trustworthy datum as to the action of a disinfectant upon a given species of organism, it is desirable at the same time as observations are made upon the disinfectant under examination, to determine the strength and time of exposure required for the disinfection of the particular race on which the examination is conducted when subjected to other common disinfectants." For this purpose they cited mercuric chloride and carbolic acid. In conjunction with Mr. Ainslie Walker, during 1903, I suggested a method—the carbolic acid co-efficient test—as an outline for the standardisation of disinfectants, so that by adopting strict uniformity of procedure and the insertion of carbolic acid as a control in every test, comparable results could be obtained by different observers; and, as the object of considerable discussion, it has happily helped to draw attention to the increasing necessity for some standard bacteriological method for the legal control of the commercial disinfectants.

(a) Paper read at the Conference of the Royal Sanitary Institute in Dublin, June, 1907.

This test has been taken as the basis for disinfectant tender forms by a considerable number of authorities, and the Board of Agriculture in their Disinfection Order (dated April 5th, 1906) now permit the employment of preparations equal in disinfective efficiency to a five per cent. solution of carbolic acid. It has been alleged that the Privy Council Order of July 27th, 1900, permitting the sale without trial of fluids containing less than three per cent. of carbolic acid or its homologues, on the ground that such fluids are not poisons within the meaning of the Pharmacy Act, 1868, has resulted in flooding the market with useless disinfectant preparations. On June 4th this year the question was asked in Parliament as to the necessity for action being taken to ensure the standardisation of disinfectants.

So as to approach as closely as possible the conditions obtained in actual practice, the introduction of a quantity of organic matter into a standard method has been suggested, and recently a number of papers have been published dealing with the results obtained under these conditions. Kenwood, in collaboration with Hewlett, and also Firth and Macfadyen, employed an emulsion of fresh urine and fæces. The effects of the solutions of definite organic substances such as gelatin, casein, peptone, mucin, serum, and also blood and urine have been investigated by Sommerville and Walker. Wynter Blyth, during 1903, in reporting to a committee of this Institute, alluded to the influence on disinfectants of the phenol class through the presence of even small quantities of organic material, and later (*Analyst*, May, 1906) he suggested milk as a suitable organic material for testing purposes, as an easily procured fluid containing a variety of organic and mineral constituents in natural proportions. In a paper read before the Chemical Society in December last he compared the figures obtained by fæces and milk, and claimed that by employing a mixture of whole and separated milk so as to adjust the amount of the fat present, similar curves of results could be obtained.

The complex question of disinfection in the presence of quantities of organic substances may be viewed from many standpoints, and there is again the danger of confusion caused by the multiplicity of results, obtained by many investigators working under entirely different conditions. Fæces are perhaps one of the most variable of organic products, and, as pointed out elsewhere, it is doubtful if the results obtained for example by Wynter Blyth could be duplicated by himself, not to mention other observers. More distinction should be made between organic matter in suspension and that in solution; sterilisation by means of chemicals can be brought about with certainty in the presence of *dissolved* organic matter, but this is not practical with germs protected by being embedded in masses of solids, until the latter are disintegrated. The sterilisation of fæces, for example, is rarely undertaken in actual practice, and after all, beyond temporarily guarding against the spread of infection during transit, such material is better left to its natural disintegration by hydrolysis in the sewage.

It will always be imperative to know for what particular purpose or purposes a disinfectant is required in order to arrive at its proper ultimate valuation, and there can be no doubt that the preparation should be scientifically tested under conditions resembling as closely as possible those that will be present during its application; but it is hopeless attempting to evolve any one single routine test that could apply to the very divergent circumstances obtaining in every-day disinfection—one that would apply equally to the disinfection of a swimming-bath, to the cleansing of cattle trucks, and to the sterilization of surgical instruments. Reaction alone, whether acid or alkaline, plays an important part in disinfection, and some preparations, depending upon a fine emulsion for their germicidal value, are considerably modified by traces of acidity. However, if a preparation that is stated in certain dilutions to destroy disease germs does not kill under the more simple conditions as those of the carbolic acid co-efficient test, it is worse than useless for any disinfectant purposes, and as a fraud its sale should be prohibited. It would be wrong to illegalise certain powerful germicides because they are rendered uncertain in their action by large quantities of organic matter, and it is surprising to find in a paper published this year such a miscellaneous list as preparations of "permanganate of potassium, eucalyptus, thymol, boric acid, chloride of lime," generally condemned as being "erroneously believed by the public to be disinfectants."

Certain oxidizing agents, such as chlorine, which attack organic matter, are not necessarily rendered ineffectual by an excess of organic material, as I have shown when disinfecting sewage effluents with electrolytic chlorine at Guildford, the pathogenic organisms were killed, even if there were sufficient organic matter present to completely remove in a few hours all the free or available chlorine added; and provided that the re-agent is added in excess of that almost immediately taken up by powerful and rapidly reducing substances, such as sulphuretted hydrogen, that may be present, the majority of the bacteria are destroyed.

It is singular that the question of time in a standard bacteriological test has not met with more attention, as although, given sufficient time, many chemicals will destroy bacteria, a limit of fifteen minutes throws out some well-recognised germicides; as an instance soap, which does not give any carbolic co-efficient, and yet has marked germicidal properties, and perhaps would with advantage displace a few disinfectant preparations which have been put on the market. Many of our most reliable disinfectant substances are unfortunately incompatible with soap, and in ignorant hands this causes great waste. Disinfection cannot replace care and cleanliness, but is at times a necessary auxiliary to them. The very act of cleaning with soap and water is in itself a form of disinfection; but occasionally more active measures are required, and when there is danger of personal infection the whole procedure should be under proper scientific control. Where there is much organic dirt it should first be removed with precaution and cremated; by doing this the greatest economy and efficiency in the subsequent disinfection is secured. Indiscriminate scattering of costly disinfectants on masses of filth is useless and wasteful.

The necessity for the power of penetration is a factor which cannot be overlooked in a disinfectant, but it is reasonable *first of all* to inquire whether the preparation will destroy the germ when it reaches it. By reason of the complexity of the subject, no satisfactory routine test has yet been devised to measure penetration.

The high germicidal values given to certain substances, notably salts of mercury, by earlier observers have been considerably modified recently. Previous fallacious results were mainly due to the carrying over of traces of the powerful germicides into the sub-cultures, the great difference between an antiseptic and a disinfectant dose not always being allowed for. This difficulty which also arises in using resistant spores as test organisms can be overcome in the case of simple chemicals, such as metallic salts, by the addition of suitable precipitants to the cultures, but the traces of the more complex phenol derivatives cannot be so certainly removed.

THE REDUCTION OF INFANT MORTALITY,

BY BETTER MANAGEMENT AND CONTROL OF THE MILK SUPPLY. (a)

By HENRY KENWOOD, M.B., D.P.H.,

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A VERY large percentage of infant deaths from zymotic diarrhœa has been attributed to artificial feeding, and condensed milk has been held to be much more dangerous than raw cows' milk. These conclusions have been arrived at from a statistical comparison of the infant deaths from zymotic diarrhœa on the basis of the method of feeding prior to death. Incontrovertible as these facts are as statistical statements, they do not, of course, afford a true quantitative expression of the extent to which milk *alone* is the determining factor of the higher mortality among those who have been artificially fed, because other important factors capable of variation in the two classes compared are ignored.

Any mere statistical comparison, on the basis above referred to, may be equally misleading when it is used to demonstrate the extent of the value of municipal milk depôts, as agencies in the reduction of infantile mortality; for our experience in Stoke Newington points clearly to the fact that the hand-fed infants, as compared with the breast-fed, are generally more handicapped by other circumstances that largely determine the matter of the survival of the infant. I refer to a lesser degree of maternal care (and, in consequence, a greater neglect), and to those circumstances associated with extreme poverty (including insufficient food, neglect to seek and obtain medical advice, insanitary environment, etc.). It is therefore extremely difficult to gauge the true proportion of those deaths that are due to hand-feeding *per se;* but there can be no doubt that the number is very considerable, and that it constitutes an appalling annual toll exacted by maternal ignorance and dirty milk.

But, despite all our efforts to foster breast-feeding, a large proportion of infants will continue to be artificially fed, and public health interests demand a guarantee of healthy cows, a sufficient standard of cleanliness of milk and the discontinuance of the very general practice in summer months of drugging it with chemical preservatives.

The milk trade does not realise to the full that theirs is unique amongst trades, inasmuch as it deals with a necessary article of food which forms the almost exclusive diet of a large proportion of the most susceptible units of the population (the infants and invalids), and that milk is unique, as an article of food, in its powers of collecting and fostering micro-organisms which are injurious to health and may be fatal to the infant consumer. It is an extremely responsible trade, and it is an exceptionally difficult one to conduct. But the public, enlightened and stimulated by those who guard their health interests, are demanding, with increasing concern, that those engaged in the milk trade shall do more to protect them. It is not an unreasonable demand, and those who fail to respond to it not only neglect an obvious duty which they owe to the community, but it is inevitable in the near future that they shall suffer from the consequences of their neglect. It is the fit alone who will survive, for the milk trade will have to be raised to a much higher standard of ideal and accomplishment. It is, moreover, greatly in the interest of the trade that the milk supply should satisfy a legitimate demand for the greatest possible purity, and that it should cease to be regarded as a not infrequent danger to infant health and life.

The greatest difficulty which has to be confronted is the ignorance at the fountain-head—the average country dairy farm. The majority of dairy farmers have made little educational advance during recent years in their appreciation of the necessity of greater care and better provision for guarding the cleanliness of milk, and the actual milkers have rather deteriorated than improved with the greater difficulty experienced in obtaining that class of labour. During a recent visit to Denmark I was struck with the greater intelligence and the better supervision exercised over the milkers by the Danish dairy farmers compared with what has been my general experience in this country. The more backward British dairy farmer will, like the Dane, improve under the stimulus of a sufficient supervision and inspection, and by the insistence among those whom he supplies of a higher standard of cleanliness of the milk.

It would be a good thing if a simple limit of dirt could be fixed, which when exceeded would warrant the condemnation of the milk as dangerous for use; the consignee would return any milk which does not reach the standard, and the farmer would then soon learn the lesson of the necessity for greater cleanliness, and where neither he nor any member of his family assisted in the milking operation, he would find it in his interest to at least exercise the necessary supervision over those who do the work. To put it mildly, too often only the most rudimentary precautions are taken at the fountain-head, and the slovenly methods of the past must make way for more cleanly ones, which involve the minute attention to detail which comes with an educated cleanliness. The state of filters and separators after use is eloquent testimony to the need for reforms. The suggestion for a diet standard (based on pus or blood cells and the volume of dirt that can be separated) has met with a wide approval, and is one of the possibilities of the near future. Excessive bacteria generally imply excessive dirt, and dirt is as bad as adulteration, if not worse.

I realise that under no conceivable conditions can we hope in general practice to collect milk which is not planted with many hundreds of micro-organisms to the c.c.; but the fact remains that by greater efforts to reduce the number of extraneous organisms which now get into the milk at the time of collection, and by preventing those from unduly multiplying in the interval of collection and distribution to the public, we should achieve a valuable and vital improvement in the purity of the milk. It is this *improvement at the source* which is so much demanded, for the excessive contamination *there* either handicaps or nullifies all the subsequent precautions which may be taken.

It is to the dicta of their trade organisation that the country dairymen and dairy farmers will turn the most willing ear. The better class dairymen have done much to educate their own farmers, and would not the Dairy Association do valuable work by publishing detailed dairy rules, somewhat of the nature of those issued by the United States Department of Agriculture, 1900, and founded on the advice offered in the published leaflets of our own Board of Agriculture?

It has often impressed me as a most discreditable circumstance in our sanitary administration that the legal powers which it is competent for any rural sanitary authority to execute have either been so ignored or badly administered that in the rural districts, where the bulk of our milk comes from, there

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(a) Abstract of paper read in the State Medicine Section at the Exeter meeting of the British Medical Association, August, 1907.

exists practically nothing worthy of the name of a sanitary supervision of dairy farms. By consequence the larger milk dealers have had to step into the breach, and in order to protect themselves and their customers from the consequences of the neglect of the proper authorities, have taken upon themselves these duties; and it is no exaggeration to state that the requirements and conditions imposed by up-to-date milk vendors under their contracts with the farmers, furnish an object-lesson of what can and ought to be done, to the best organised and most advanced rural sanitary authority in this country. But this is an unfair tax upon the milk trade, and if rural sanitary authorities did their duty it would be unnecessary. From information obtained in 1903 by the *British Medical Journal* from Medical Officers of Health of counties and of combined sanitary districts, it appeared that in England and Wales, as a whole, some 30 per cent. of the sanitary authorities had made no regulations under the Dairy and Cowsheds' and Milkshops' Order, 1885; that very few of those who made regulations had provided efficient means for the supervision which is necessary to ensure that they are carried out; and that under the Order of 1889 (for dealing with tuberculosis of the udder) only four had arranged for any measure of veterinary inspection of milch-cows.

This year Mr. Burns made a statement in the House of Commons to the effect that there are at present some 20 per cent. of authorities without the regulations empowered in 1885—20 years ago!

All local authorities should be compelled to adopt and enforce suitable and sufficient regulations, and the Local Government Board should appoint inspectors to see that these are enforced. Moreover, a Bill should be drawn up for the purpose of empowering the County Councils to supervise the execution of the regulations and to take over and execute the powers of defaulting authorities and to charge the expenses to defaulting districts.

It is clear that the fundamental difficulty in obtaining these most necessary reforms is that the sanitary authority who administers the law in rural districts generally consists of those who have the least interest in making it effective, and who often deliberately make it lax, because the adoption and proper enforcement of the existing powers at their disposal would affect their pockets. It is this circumstance which gives great weight to the plea for making the responsibility for the necessary control and inspection of the milk industry a central and national one; and a further argument is the circumstance that otherwise the conditions imposed will vary in their stringency in different districts, and thus affect the trade unequally and unfairly. In default of such a national control the County Councils and County Boroughs must be charged with special powers and duties in this connection—an alternative which, while presenting advantages over existing conditions, is immeasurably inferior to a central control for the whole country. Why, in any event, should not the execution of the above-mentioned powers be subject to more supervision by a Government Department? They transcend in their importance to the public health the legislation dealing with the sale of food and drugs, yet in this matter the central authority keeps in close touch with all local authorities, frequently making representations with reference to the administration of the Acts, and giving advice upon the difficulties encountered; but our milk supply is comparatively neglected by them.

You will agree with me that another very necessary reform is the annual licensing of all premises where milk is either sold or collected or prepared for the purpose of sale. This has already received legal sanction in the Liverpool Improvement Act, which dates as far back as 1867. The conditions of the initial grant of the licence must be the suitability of the premises and the sufficiency of the general arrangements for the important purposes to which they are put, and the annual renewal must be conditional upon the maintenance of these at a satisfactory sanitary standard. There is another precedent for this in the annual licensing of slaughter-houses, and none will dispute the greater claims which may be urged in favour of licensing dairies and shops where milk is sold. The provision would, of course, apply to dairy farm premises, none of which should be licensed unless adequate arrangements exist for cooling the milk; and under its operations it is to be hoped that milk will no longer be sold in shops fully exposed to dust and flies, and more particularly in such places as chandlers' shops.

Such a requirement would not hit anyone who was conducting the business with due regard to the bare necessities of the case, but it would eliminate a few from the trade who should not be allowed to continue to carry it on to the public danger. It is not necessary that the premises licensed should be structurally elaborate; elaborate cleanliness is what is wanted; and the means for securing this, and the evidence of a conscientious and intelligent effort to maintain it, should determine the granting and renewal of such licences.

The arguments in support of the frequent veterinary inspection of cows the milk of which is used for human consumption (whether as milk, cream or butter) is overwhelming.

I believe that you will agree that such an inspection cannot be provided by the rural and small urban sanitary authorities, for many reasons, and it certainly would not be fair to saddle all the expenses involved upon the dairy districts. Failing these authorities, the duties would devolve upon the County Councils, and, failing them, upon the Local Government Board or the Board of Agriculture. Personally, I should favour a system of quarterly inspection under one of the latter boards, but it might be undertaken by the County Councils and the County Boroughs, and I would give them power to act quite independently of the local sanitary authorities. But some fair measure of compensation should be provided (as under the London County Council (General Powers) Act, 1904), when animals infected with tuberculosis have to be removed from the herd and slaughtered. I am out of sympathy with the antagonism evinced in many quarters against a fair measure of compensation in such a scheme. The cost, having regard to the important issues at stake, and to the fact that it would remove the formidable barrier which trade opposition can erect against legislative action, is small, and would tend to grow smaller year by year, and without it the scheme of veterinary inspection will be under a great disability. Under most milk contracts with farmers the farmer is exempted from any loss which might result from his giving prompt information of the existence of infectious disease in anyone connected with the cows and the milk. This is found to be a valuable concession as guaranteeing that the necessary information will not be withheld; it is for a similar reason that I advocate compensation for the compulsory slaughter of the milch cows, and my advocacy is strengthened by the circumstance that the clinical diagnosis of tuberculosis is often very difficult. I would not advocate a full measure of compensation, for some loss upon a tuberculous animal will serve as a stimulus to many farmers to be more careful what they buy, and to do more (especially in the matter of the ventilation of the sheds) to keep cows free from this disease. To further the ends of this necessary veterinary inspection, the Board of Agriculture should make tuberculosis in milch cows a notifiable disease, and it is not too much to require that farmers should be compelled, under a penalty, to notify any udder diseases in a milch cow, and to refrain temporarily from selling the milk of cows so affected, pending the veterinary inspection. The scope which at present exists for reduction of tuberculosis in bovines, without seriously interfering with the conduction of the trade or increasing the cost of the milk to the public, is demonstrated by the operation of the L.C.C. and Manchester Milk Clauses, the latter Act having led to a reduction of the number of tubercular samples sold by over 40 per cent.

But all along the line there is need for reform, and for many reforms which the trade itself should do more to promote. Time, however, demands that I should conclude my opening remarks within a few minutes, and those I propose to devote to a very important issue of the milk question. Although I am confident of great advances in the near future, I do not expect to see such a measure of improvement as would lead me to recommend the feeding of infants with raw milk in the summer months, when Pasteurisation appeals to me as a measure of enormous public health value, as much preventable disease would thereby be prevented, and we should have no more drugging of milk with chemical preservatives. And as the contamination of the milk in the home is a circumstance which is responsible for much of the evil consequences of the consumption of raw milk in the summer months, I am confident that before long all milk will be sold in bottles. This represents an important advance in the right direction, when the proper means are provided for thoroughly cleansing the bottles by steam under pressure, and for filling them at headquarters. The bottle protects against the access of dust and flies before and after the milk reaches the home, and it is almost a guarantee of unwatered milk and of full measure.

I believe that in no other civilised community is raw milk consumed in such proportion as in our own country, and yet practically all leading authorities in this and other countries inveigh against its use, especially in the summer months. Is it not clear, then, that in the interests of preventive medicine we should make the dangers of artificial feeding the argument for obtaining breast-feeding whenever possible; but, failing that, we should discourage the employment of raw milk for infant-rearing until we attain to (if it is attainable in general practice) an absolutely pure milk supply? But although we shall certainly much reduce the dirt in milk, it is inconceivable that we shall ever do away with it entirely. Even with a much-vaunted supply in Copenhagen, I was astonished to see the large amount of dirt present in the milk arriving at the depôt. Now the alternative to raw milk is to heat it to a temperature which represents Pasteurisation or to the far higher temperature of sterilisation.

With regard to the prolonged use of sterilised milk, it is conceded that some danger exists, but there is a tendency to a great exaggeration of the danger in this country. This is the view of many competent authorities with whom I have discussed the subject, and the following facts support the view.

What is the experience in this country? There are each year many thousands of infants up and down the country who are fed upon sterilised milk, and there has been for some years a large market for such milk; the use of (sterilised) condensed milk for infant feeding is also a very extensive one; yet the testimony to its evil effects is trifling. The bulk of the milk supplied at institutions to infants in this country is either sterilised or Pasteurised, and wherever sterilised milk has been given out in infant milk depôts there has been no mention of infantile scurvy. But the Registrar-General's reports afford perhaps the best justification for the pronouncement in favour of the harmlessness of sterilised milk, for, despite the extent to which it is used at the present day in this country, we find that only ten deaths occurred from scurvy among infants under one year of age in the vast community of London during the three years 1903, 1904, and 1905, whereas for every such death about 800 deaths were certified from diarrhœa (stated to be due to food), epidemic diarrhœa and infantile enteritis, and diarrhœa (not otherwise defined).

What is the experience abroad? In America, Denmark and France, each with an extensive experience covering many years, the verdict is favourable to sterilised milk. Dr. Variot, whose experience is unique, since his feeding experiments at the "Goutte de Lait," at Belleville relate to over *3,000 healthy as well as unhealthy children who were closely observed by him for many months*, has seen nothing of infantile scurvy resulting from the use of sterilised milk. The facts collected from the experience of other such institutions abroad, and from the Consultations des Nourissons in France, are further testimony to the almost absolute harmlessness of sterilised milk. On all sides the general experience is that extremely little scurvy results from the use of such milk, and the late Professor Budin, whose "Consultations" are now established all over France, and were first started in 1892 with the object of advising and helping French mothers in the healthy rearing of children, wrote to me under date April 6th, 1906, that as the outcome of his wide experience he had not seen a single case of infantile scurvy resulting from the use of sterilised milk.

This is not the place to discuss the etiological relationship of the prolonged use of sterilised milk to scurvy in the infant, but the absence of that unknown quantity, "the anti-scorbutic principle," can only at most affect those patients with a very rare idiosyncrasy. But although it is granted that the use of sterilised and boiled milk occasionally harms a child (for this is testified to by those whose findings are authoritative and beyond dispute), it cannot be in the public interest to discourage its use in face of the overwhelmingly greater dangers of raw milk. If one sets the danger of sterilised and boiled milk against that of the raw article, the former danger sinks into insignificance by the side of the latter. Those who rail against the use of sterilised milk say, in effect, that rather than one child should suffer from scurvy, some hundreds may be left to die of zymotic diarrhœa, etc. There is, however, practically no evidence that Pasteurised milk has caused infantile scurvy, and it possesses the additional advantages over sterilised milk that its taste is unaltered, the physical changes brought about by Pasteurisation are practically nil, and the digestibility is not impaired; and, furthermore, Pasteurised milk is consumed in a fresher condition than sterilised milk.

As to the provision of municipal milk depôts, I am not, I must confess, enthusiastic. That they are valuable object-lessons to the community (including the trade) I have no doubt, but I believe that educationally and sociologically the provision of infant consultations, as inaugurated by the late Professor Budin, are to be preferred. Such provision was made a little more than a year ago at the St. Marylebone General Dispensary, London, and the results appear to be (so far as one can judge from statistics) at least as good as those obtained from the Metropolitan municipal milk depôts. Through the efforts of Dr. Sykes, "A Mothers' and Babies' Welcome," with similar aims to those of the "Infant Consultations," has recently been established in St. Pancras, London, and is doing excellent work. I am of opinion that the mothers should be left to obtain the milk through the ordinary commercial channels, and that those milk vendors should be recommended who are willing to conform to the conditions imposed by the directors of the Consultation.

In conclusion, I know that there is among medical men a general agreement with my main contentions, and yet in this, as in other matters, we muddle along and delay the day when the full beneficent results of our knowledge will be reaped.

The President of the Local Government Board has stated that he proposes to make legislative proposals on his own account next year. At the risk of being judged presumptuous, I would suggest that what is wanted more particularly is *stringent* legislation, embracing, above all, a scheme of *efficient inspection* of dairy farms and milch-cows; and, with reference to certain matters that do not lend themselves to effective legislation, an authoritative pronouncement by the Local Government Board. As to the matters referred to in the latter category, let me remind him that in other countries neither the public nor the trade is left in doubt that what is the correct thing to do is to avoid the use of raw milk, at least in the summer months, and Pasteurisation and sterilisation is encouraged. Those responsible for the public health in New York and some other American States have made no secret of their preference for Pasteurised milk. The consequence is that the trade has responded, and a considerable reduction in infantile mortality is claimed as the result of its very general use. In France they have made up their minds on the subject, and the French Minister of Public Instruction has advocated the use of Pasteurised, boiled or sterilised milk as a precaution against disease. The central authorities in Denmark and Germany have also given advice on the subject. But in this country no such lead is given. If the public were informed by a Government department what it is they ought to demand, the trade (at present distracted by all sorts of conflicting views and statements) would the sooner fall into line.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

Operation for Ruptured Gastric Ulcer.—Mr. **Peyton Beale** operated on a coachman, æt. about 35, who had been admitted, under the following circumstances: at two o'clock in the afternoon, having had no food since breakfast, he was seized with sudden and very severe pain in the abdomen; it started in the lower part in the region of the bladder, then extended to the right iliac region and right loin, and when he was admitted at about 3 p.m., was found to be most severe in the gall bladder region. There was a history of rheumatic fever, and the man had aortic and mitral murmurs. His chief complaint was difficulty of breathing. The pain was so severe that he was obliged to sit up, and he was sweating profusely. He was admitted and ordered to be kept very warm, and fomentations were applied over the abdomen. He vomited once only, bringing up some bile-stained fluid. There was practically no distension of the abdomen, but there was very well marked dulness in both flanks. At 8 p.m., about five hours after admission, his condition was as follows: pain localised to the epigastrium, slight abdominal distension, marked dulness in both flanks, no vomiting, temperature 99, and tending to rise, pulse 120, considerable respiratory difficulty except when sitting up. He had given an old history of indigestion extending over some months, but at no time had he suffered from hæmatemesis or from melæna. It was considered advisable to explore the abdomen at once, so, the usual preparations having been made, the abdomen was opened in the right linea semilunaris. A quantity of turbid fluid at once escaped, and there was little doubt that this came from the stomach. On inserting the hand into the abdomen and exploring the stomach, a perforated ulcer about the size of a threepenny piece was detected in the smaller curvature of the viscus close to the pylorus. This was with some difficulty brought to view, its edges were rapidly excised and several sutures introduced in order to approximate the borders; more sutures were then used to bring together the peritoneal covering of the stomach and thus to close over the line of previous sutures. The stomach was next explored, but no other ulcer could be detected. The abdominal cavity was then washed out very freely with hot sterile salt solution and the abdominal wound closed, two gauze drains being inserted at each extremity. The patient was put to bed and ordered to be given as much morphia as might be necessary to keep him absolutely quiet. The whole operation lasted about twenty minutes. Mr. Beale said that in his experience the elements of success in these cases rested upon the carrying out of the following conditions: First, to operate at the earliest possible moment, even though there was considerable doubt as to the diagnosis, confirmation of the diagnosis often not being obtained until general peritonitis was well advanced, to wait until this occurred was, of course, in most cases fatal; secondly, to operate as quickly as possible, and not to insert more sutures than were absolutely necessary to approximate the freshened edges of the ulcer. If the ulcer were larger than a threepenny piece, it was always wiser and really quicker in the end to open the stomach freely on its anterior aspect and sew up the ulcer from within, subsequently closing the stomach incision with a continuous suture; this procedure was, of course, always necessary when the ulcer was situated at all posteriorly. The process of dragging the stomach up in order to reach the ulcer in the ordinary way was, he considered, very dangerous. Thirdly, to operate in a very hot room or theatre, to have all instruments and lotions as hot as possible, for he was perfectly convinced that the greater part, if not the whole, of the shock subsequent to abdominal operations was due to exposure to cold; fourthly, to keep the patient fully under morphia for two or three days after operation, that is to say, to administer sufficient morphia to keep the patient perfectly quiet.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Aug. 18th, 1907.

Exophthalmic Goitre.

Numerous are the theories put forward relative to the cause of exophthalmic goitre, but only two of the group claim attention—nerve and thyroidian theories. The former incriminates either an affection of the bulb or of the sympathetic system.

Authors who pronounce in favour of disorders of the bulb invoke the co-existence of cardiac troubles, vaso-motor troubles on which might depend the goitre (congestion of the thyroid), and exophthalmia and the trembling, from paralysis of the cranial nerves.

The theory which attaches Graves' disease to a lesion of the cervical sympathetic is based on the theories of Claude Bernard and more particularly those of Abadie. For Abadie, there existed a permanent excitation of the vaso-dilating fibres of the cervical sympathetic or of their nuclei. The origin of the vaso-constrictors being abolished, the carotid arteries and those of the thyroid gland, dilate, and the result is hypertrophy of the gland from turgescence of its arteries, hence goitre; the vessels of the bulb dilate also, hence exophthalmia. As to tachycardia, it is the direct result of the disturbance of the great sympathetic. Thus, the three great symptoms of the malady are easily explained.

Plausible though it be, this theory is being gradually abandoned as lesions of the sympathetic are far from being constant in Graves' disease, and, according to Francois Franck, the sympathetic exercises no vaso-dilating action on the thyroid body. Yet the conception of Abadie deserved mention, as it had as a consequence, originated the surgical treatment of exophthalmic goitre by section of the cervical sympathetic.

Much more important would be the thyroidian theories, which are two in number, one sustained by Ganthier, incriminating perversion of the secretion of the gland, the other exaggeration of this secretion (Mōbius).

The last-named is based on clinical facts. In myxœdema, which results from thyroidian insufficiency symptoms are observed (atrophy of the thyroid body, sensation of cold, lowering of the central temperature, dryness of the skin) which are exactly the reverse of the symptoms of Basedow's disease. On the other hand, MM. Ballet and Enriquez reproduced, by injecting thyroid extract into sheep, a certain number of signs of exophthalmic goitre.

For M. Boix, neither of these theories should be considered absolute, as we have not yet arrived at a perfect knowledge of the nature and cause of the malady.

Treatment.

The treatment is either medical or surgical. The medical treatment is very important, and can, if properly carried out, cure the patient. Absolute rest in bed should be prescribed, where the symptoms present the slightest gravity; this means alone are sufficient to moderate the cardiac palpitations and the nervous agitation. In every case, the patient should be guaranteed from all excitement and brain worry. Country air is very beneficial, but a sojourn at the seaside is counter-indicated.

As to medical treatment proper, digitalis has been prescribed for palpitations.

Trousseau recommended it in large doses until symptoms of intolerance set in, while Jouffroy recommended strophanthus. But Dieulafoy considered either of these drugs as more or less hurtful, and they should be reserved for cases of weakness of the cardiac muscle, with dilatation of the cavities and a tendency to asystolia. He prescribes, on the other hand, ipecacuanha.

Hippo powder, 1 gr.
Digitalis, ½ gr.
Ext. of opium, 1-10th gr.

For one pill. Two, three, or four daily, and continued for months.

Agitation and insomnia are best treated by bromides or valerian and febrile attacks by antipyrine (Huchard), salicylate of soda (20 gr. four times daily) gave good results in the hands of Chibret and Babinski.

Hypertrophy of the thyroid body has been treated by iodine and iodides, but, according to Dieulafoy they do more harm than good. The same might be said of ferruginous preparations.

Among physical agents, hydrotherapy procures frequently excellent results. The cold douche may be ordered, but in order to accustom the patient to the cold water, warm douches might be given for the first two or three days.

Electricity is one of the best therapeutical agents; it is local and consists of two great methods—that of Eichorst, utilizing galvanisation, and that of Vigouroux, employing Faradisation; they may be associated.

The seance may be commenced by galvanisation, one plate on the tumour, the other on the back of the neck. The seance should be from one to ten minutes, according to the tolerance of the patient. Then Faradisation of the orbicular region, the sides of the neck and the precordial region should follow.

The duration of the electric treatment is from three to four months. Decrease of the goitre, attenuation of the trembling, improvement of the general condition, are frequently observed after the first few seances. According to Delherm, improvement in the palpitations and the exophthalmia is much slower.

As to opotherapy, it has but little place in the treatment of exophthalmic goitre; iodo-thyrine would be only beneficial where the malady depended on defect of the secretion of the thyroid gland, which is far from being proved.

Gilbert Ballet and Enriquez imagined an immunising serum taken from the horse or the sheep, from which they had previously removed the thyroid gland. Mixed with glycerine and given at the dose of three teaspoonsful a day, it has given encouraging results. All the symptoms improved rapidly—goitre, palpitation, exophthalmia and trembling.

The surgical treatment consists in total or partial thyroidectomy, resection of the cervical sympathetic, operations which may be regarded as generally useless, and should be only counselled as a last resource.

The treatment of Graves' disease requires great patience, and the physician should know how to vary his treatment according to the particular case. But if intelligently applied, the treatment procures in the large majority of cases, if not a complete cure, considerable improvement and prolonged remissions.

GERMANY.

Berlin, Aug. 18th, 1907.

At the German Society for Surgery, Hr. Kausch, Berlin, discussed the subject of

Contracted Bladder and its Treatment.

He first described the various causes of the abnormally small bladder (congenital, neuroses, affections running their course outside bladder, inflammatory growths, tumours lying within the bladder, and calculi; concentric hypertrophy). By far the most frequent cause was interstitial cystitis with disappearance of the muscular walls (contracted bladder). The condition of the severe cases in which the bladder capacity fell to 10-20 ccm was intolerable; at last all the patients died with ascending inflammation.

The treatment consisted in dilatation of the bladder; this, however, when inflammation was present or when it supervened was out of the question and did no good. In one case a suprapubic fistula was formed and the sufferings of the patient were very much diminished.

The speaker in one case, that would be more fully related, had totally disconnected a loop of small intestine and brought it into connection with the bladder, the capacity of which was only 20 ccm. The patient was discharged cured, continent, with a capacity of 200 ccm. The procedure might be advisable in cases that could not be relieved in any other way or in which the bladder had been totally or almost totally extirpated.

Hr. Schmitt, Munich, observed that none of the operations at present employed secured complete continence. Maydl's method of implanting the ureters into the bowel still gave the best results.

Hr. H. Jacoby, Berlin, showed apparatus for stereocystoscopy and stereocysto-photography and also photographs produced by them.

Hr. Ringleb, Berlin, believed that vision was not stereoscopic with the apparatus shown, but that with Nitze's instrument it was easy with practice. It was not to be denied, however, that stereocysto-photography was an important advance.

Hr. Körte, Berlin, had performed Maydl's operation in one case, continence was not complete, but the patient was very much improved.

Hr. Kümmell, Hamburg, greeted Rovsing's method of performing total extirpation of the bladder as an important advance. Total extirpation of the bladder for carcinoma was always very fatal. In two non-carcinomatous cases the results were better; in one case death took place 4 years after from ascending disease; in the second case, that of a boy, death took place in a year.

Hr. Riedel, Jena, had been successful in one case; a second one died of ascending pyelitis.

Hr. H. Stettiner, Berlin, showed a case of

Multiple Intestinal Atresia.

The patient, an infant æt. 13 months, presented the deformity of Atresia ani urethralis or Atresia ani et communicatio recti cum parte prostatica urethræ as Stieda called this form of malformation. The first operation was performed on the second day after the birth of the child, and consisted in making an opening to the blind end of the rectum and suturing it to the place where the anus should have been. The second operation was performed four weeks afterwards, the object of which was the abolishment of the communication. Here also the operation was performed from the perineum. The urethra tore at the point of communication and a Nélaton's catheter had to be sutured in. The opening in the rectum was also closed and the operation concluded with a procto-plastique. A perineal urinary fistula formed at first but closed later. Urination was now normal, the bowel function was not perfect but satisfactory. Communications of the blind end of the rectum with the urinary organs were met with at three spots, most rarely at the summit of the bladder, most frequency at the base, and thirdly at the prostatic part of the urethra. Whilst the first named malformation required laparotomy, separation of rectum and bladder, suture and pushing down of the blind sac to the perineum with proctoplastique, such as Lotsch had lately carried out successfully in a case, with deeper seated communications the operation should be carried out from the perineum. He would do the operation at two separate sittings but would not put off the second to a later age, but at the most for two to six weeks after the first part.

He also showed the bowel of a child with multiple stenoses on which the operation for artificial anus had been performed 24 hours after birth, but which died 60 hours after the operation. At the *post-mortem* it was found that the small intestine ended in a blind sac 75 cm. below the pylorus. This blind end lay in a tangle of matted loops in which the blind end of the further portion of the small intestine lay. This was at first much dilated, and it was here that the artificial anus was made. Next to this was a mass of thin twisted serpentine loops, then the normal colon with a large vermiform appendix and the rectum only the size of a pen holder. There was also a good deal of peritonitis probably secondary. It would have been better to have operated from the abdomen so that the requirements of the case could have been met.

AUSTRIA.

Vienna, Aug. 18th, 1907.

A New Function of the Pancreas.

Professor Loewi, in a long paper read before the members of the Gesellschaft, raised a new point in connection with diabetes mellitus, which had been excited in his own mind by the experiments of Eckhard, who demonstrated a short time ago that, if the sympathetic could be inhibited, irritation of the nerve, either centrally or peripherally, would produce sugar in the urine by the transformation of glycogen. If the pancreas possesses this function alone of irritating the sympathetic which has been proved to cure the diabetes in some experiments, by its removal, we have in our hands a speedy remedy for the disease. With this argument in view, Loewi commenced the examination of the hypothesis from another point. The dilator muscle of the pupil of the eye is the best index of the sympathetic at our command. If adrenalin be dropped into the normal eye no mydriasis will appear, as this drug stimulates the motor fibres of the sympathetic; but if the cervical ganglion be removed twenty-four hours before dropping in the adrenalin, mydriasis will appear. Now of 18 diabetic patients to whom Professor Loewi administered the adrenalin to, 10 of them suffered afterwards from mydriasis. Of 28 other patients suffering from other diseases, only two had mydriasis, viz., one suffering from occlusion of the pancreatic duct according to clinical diagnosis, but no glycosuria was present. From this he assumed that the two functions of the pancreas can be separated. The other case that acted was one suffering from morbus Basedowi, which from this reaction may have some close connection through the sympathetic nerve system.

Freund thought this an important contribution to our knowledge on a very abstruse and obscure subject in medicine. From a chemical standpoint, Professor Loewi's theory was interesting. We have a series of clinical observations very conflicting when an attempt is made to reduce them to order but if a chemical insufficiency in the hepatic cells be accepted this would interfere with the function of the organ and prevent the sugar being converted into glycogen. In 1902 he had a considerable amount of discussion and examination of cases which resulted in the opinion that different forms of diabetes mellitus were due to vascular paralysis, supposed to be due to central irritation as well as peripheral, causing a dilatation of the vessels that had no power to contract. Toxins and antitoxins possessed the same property of paralysing.

Falta thought that Professor Loewi's theory had a wider interpretation as it could be extended to the Naunyn school, which believed in the disturbance of glycogenic circle by the loss of power in the lung to burn up the superfluous grape sugar. Freund's chemical theory might be true of slight or simple forms of diabetes mellitus, but in severe cases no clinical argument could support it; indeed, experimental pancreatic diabetes contradicted it. The burning up metamorphosis seems to have more clinical support than ever. At this point Freund reminded Falta that Külz founded the whole of his chemical theory of diabetes on purely clinical evidence, and not on laboratory experiments like these of Loewi's.

Loewi replied that his experiments with the stimulation and inhibition of the different fibres of the sympathetic were not stimulation and inhibition of the vascular nerves nor on the consumption or expenditure of oxidisable material, but rather a physiological function in the nerve system existing between this and the spleen. His theory is purely experimental, although, curiously enough, the 28 cases given above support the theory in the sugar metamorphosis.

Injury to Neck With Paralysis.

Heyrovsky presented a case of some interest from its subsequent development. The patient was æt. 62, and in January, 1906, received a stab in the left posterior side of the neck. The external jugular vein was slit open for some distance, but beyond that no other untoward circumstance was present.

The wound healed kindly in a very short time, but suddenly one day an unusual sequence was discovered in paralysis of the left recurrent nerve from a probable injury of the left vagus which appears to have involved the left sympathetic as myosis and enophthalmos were present. On closer investigation it was ascertained that the myositos and enophthalmus or contraction of the pupil and retraction of the eye-ball were noted immediately after the accident, but it was expected they would recover on the wound healing; but instead of disappearing they have become more accentuated.

The question arises concerning the real site of the lesion. Injury to the recurrens or vagus will affect the vocal cords as it has done in this case, but the sympathetic is also involved. The respiratory signs and frequency of pulse are absent, which usually accompany injury to the vagus, but the paralysis of the left vocal cord is present, which would indicate that the recurrens and sympathetic alone are injured.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THREE TERM SESSION IN EDINBURGH UNIVERSITY.

The King in Council has approved a new ordinance which will effect very important changes on the Edinburgh medical curriculum. The question of a three term session, with corresponding alteration of the dates and sequence of the professional examination has been under the consideration of the various governing bodies of the Association for some years back. The originator of the reform, which has now been accomplished, was Professor R. J. A. Perry, now of Melbourne, and the new arrangement will, it is believed, lighten the burden of the student by enabling him to take his classes and examinations in a more convenient order, and will not lessen his work, but allow of its being expended with more profit to himself. The ordinance has been delayed through the opposition of the Universities of Glasgow and Aberdeen; the tradition has been that all the universities toe the line together, and the pace of progress is that of the most conservative and slow moving. Even were the ordinance in itself trivial, it would be important in the earliest step towards autonomy on the part of any one university, for it is the first ordinance in which one university has struck out a line of its own, and has not waited for conjoint action with its fellows.

The new arrangement will remove one anomaly, namely, that materia medica will no longer be studied before pathology, and then the student will know something of disease before he comes to its remedy. An outstanding feature is the division of the winter session into two half sessions—October to Christmas and January to March. Professional examinations will now be held thrice yearly—December, March, July, at the end of each term. At present there is no professional examination at the end of the second year, consequently slackness is engendered among the students, and the third year is burdened by arrears. Now an examination in physiology is provided at the end of the second year. In order to leave more time for clinical and practical work the examination in anatomy may be taken three months earlier than before. The examinations in materia medica and pathology have been transposed, so that the latter now precedes the former. The final examination may now be taken in four parts. Forensic medicine and public health may be taken at the end of the summer session preceding the final winter, and midwifery at the following Christmas. In March, at the end of the final year, systematic medicine and surgery can be taken, and clinical medicine and surgery in the summer thereafter. The present final drags a weary course of two months, all subjects being taken at once, this involving about eighteen separate appearances for examination. Being now allowed to distribute his work over a larger period greater proficiency and a higher standard should be attained and ought to be exacted. The new regulations will apply to all students, future and present, and take effect in October.

TYPHOID FEVER AT PETERHEAD.

A somewhat extensive epidemic of typhoid fever fortunately of a mild type, has been in full swing in Peterhead for the past month, during which period nearly 200 cases have been notified. The source of infection has been found in one of the reservoirs, the water of which has accordingly been cut off. In the herring season especially, this deprivation of part of the usual water supply has been greatly felt, and the Government authorities are helping the town as much as possible from their special supply used for the convict prison, having placed at their disposal between 30,000 and 40,000 gallons per day. The epidemic was at first thought to be connected with the milk supply, but Dr. Dittmar found that it was too extensive to be accounted for by this, and traced it to the water. He states that a purer and larger water supply is required by the town, which has outgrown the present sources. The present springs require protection from pollution, and stream and surface water should be excluded. Since the epidemic began there have been 216 cases with only 12 deaths. Fortunately for the prosperity of the town, the population of which has swollen from 13,000 to 18,000 during the fishing period, this industry has not been interfered with by the epidemic, and no strangers have been among the patients. A fresh water supply has been under consideration for some years, and a scheme is now being adjusted which will give the town an abundant supply for the next quarter of a century at a cost of about £10,000.

BELFAST.

Bangor Nursing Society.—The annual meeting of the Bangor (Co. Down) District Nursing Society was held last week, the president of the Society, the Dowager Marchioness of Dufferin and Ava, in the chair. In recounting the year's work the president said that their nurses had had 260 cases under their care, and had paid 5,645 visits. The Society had also given help in the form of food and clothing to many necessitous cases. Professor Sinclair, F.R.C.S., moved the adoption of the report. After speaking of the need of such societies as this, and the amount of human misery which they relieved, he dealt at some length with the subjects of infantile mortality, medical inspection of school children, and the physical degeneration of the race. He pointed out that in dealing with all these important problems the district nurse had a part in the work. Lady Helen Munro-Ferguson also spoke, and told the ladies present "that while they looked after the work of their Society among the poor, it was also their duty to see that their nurses were properly remunerated, had provision made not only for the present, but also for the wants of old age, did their work under the best conditions, and had that recreation and change which ensured the maintenance of their good health and, what was equally necessary to that success, their good spirits."

Up to August 14th, 132 cases of cholera were reported to have occurred in Samara, 36 of them ending fatally. Twenty-five cases and six deaths occurred in Astrakhan. Two deaths from cholera are reported from Yaroslavl.

LETTERS TO THE EDITOR.

MILK AND TUBERCULOSIS.

To the Editor of The Medical Press and Circular.

Sir,—I have yielded to the suggestion of "A Family Doctor," and I have very carefully read (but not without some impatience at the absence of *facts*) this paper to which he refers me. From the beginning to the end I do not find a single *fact* that can be regarded as *evidence* in support of the view of the writer. It is all pure assumption, and the following sentences condemn his views beyond the hope of reprieve: "This disease (tuberculosis) is insidious in its approach; its period of incubation is unknown; the signs of its presence are for a considerable time indistinguishable from those of other ailments; and the means of tracing its probably remote origin *are not available. Hence the impossibility in the present state of our knowledge of presenting evidence of the extent to which the disease may be attributed to milk* or any other individual cause." I endorse his quotation, viz., "If there be anything like the danger from the meat and milk of tuberculous cattle that medical officers of health say there is, we should all have been dead of tuberculosis long ago."

In spite of what the writer of the paper says, viz., "That the cowhouses in the rural districts are as insanitary as ever," and of all the causes that are at work in the production of this disease, it is an incontestable fact that the disease is becoming less prevalent under the improved conditions of life at present existing.

If, then, I fail to find anything in the paper with the slightest pretence to evidence, and the advocates of the theory involved fail to produce one solitary instance in which there was even a suspicion that the disease had been communicated to a human subject by means of milk, I must continue to hold my present views in which I feel myself fully justified, and I am not in a position to confess that they can no longer be maintained."

"A Family Doctor" appears to accept statements that are not supported by any evidence. I am not in that frame of mind.

I am, Sir, yours truly,
George Granville Bantock.

August 17th, 1907.

THE NEW ADVANCE AT THE INTERNATIONAL CONGRESS OF SCHOOL HYGIENE.

To the Editor of The Medical Press and Circular.

Sir.—As a slightly incorrect statement has been published it would be as well to explain in some detail the important new move in the matter of School Hygiene which was taken at the closing meeting of the recent International Congress. The permanent International Committee consisting of about sixty members selected from almost every country has hitherto only met during Congresses. Arising out of the question of whether it would not be a proper thing to establish a Bureau, with a permanent staff, library and museum, and so on, in some central but neutral spot, such as a Swiss or Dutch town, it was decided, as explained by Drs. Mathieu, Burgerstein and Kerr, that it would probably lead to greater progress if such Bureau was not localized, but if each country had its own centre for the diffusion of knowledge, and to act as a clearing house in the matter of School Hygiene statistics laws and regulations. Finally, to supervise in scientific matters and generally to do all that is possible at all times or places to forward the human interests which are bound up in the special lines of knowledge included in School Hygiene, the International Committee has formed a small Council.

This Council has all the powers of an ordinary Committee. It can form sub-committees of experts on special enquiries. The usual Committee procedure is to sit round a table and discuss matters, but this Council will deal with the various subjects that arise, submitting the different topics by correspondence.

collating the answers, and, finally, making pronouncements in urgent matters after a meeting of the Council.

It is obvious that for efficiency such Council should be small and yet have in the elements to secure permanence, and, at the same time, possibilities of slow but constant change. This has been done by deciding that it shall consist of the president of the past Congress, the president of the Congress which has just been held, and the president of the next Congress. Nine other members are to be elected, of whom three are to be from the country where the Congress was last held, and three from the country where it will be held next, three being selected from other lands.

Certain matters for instance will almost at once come under the consideration of this Council. Such might be quoted as:—

"The question of how medical inspection of schools can best be carried out with the maximum of efficiency and minimum of cost."

"The question of how far the laws of health can best be imparted to the coming generation, so that later they will know how to care for themselves and those dependent on them."

"The best systems or methods of physical training for both sexes at various ages."

"The feeding of children requiring proper nutrition, so that it shall be done without developing pauperism and with regard to those upon whom the cost falls."

These four matters are being dealt with practically in a great variety of ways, and this Council should be able to collect and analyse known facts to show which methods are best for any town or State.

It is obvious that information thus digested will have a very great value politically as well as educationally, and this Council may in time come to be officially regarded as quite analogous in matters of School Hygiene, to that other Congress of Peace now in session at the Hague.

I am, Sir, yours truly,
Lauder Brunton, President.
E. White Wallis,
James Kerr,
Hon. Gen. Secs.

QUACKERY IN DRUGS.

To the Editor of The Medical Press and Circular.

Sir,—One of the best plans of scotching the quack medicine trade would be for all retail chemists to write and refuse point blank to stock such articles, and in addition, if all medical men would begin again to write prescriptions, as in the past, the difference would soon be felt, if only by the inconvenience experienced in endeavouring to obtain the articles so largely advertised by those who will not pay a doctor, but prefer self-medication. The gain eventually to both retail chemists and medical men themselves would certainly be appreciated.

I am, Sir, yours truly,
Alexander Duke.

London, W.

P.S.—The curse of the nation is self medication.

OBITUARY.

W. H. BROWN, M.Sc., F.R.C.S.I.

We regret to announce the death of Dr. W. H. Brown, the well-known Leeds surgeon, which took place at Headingley, Leeds, on August 15th. Two years ago, while performing an operation, Dr. Brown contracted blood poisoning, and up to the time of his death he never succeeded in completely throwing off the effects of that illness. For some time past his condition has been serious, and the announcement of his death was not unexpected by his friends.

Dr. Brown spent practically the whole of his life in Leeds. He received his early training at the Leeds Grammar School, and subsequently studied medicine at the Leeds School of Medicine. He obtained his M.R.C.S. (England) degree in 1878, and almost continuously from that time to his death Dr. Brown was connected with the Leeds General Infirmary. After filling the position of resident house surgeon he was appointed resident surgical officer. In the year 1884 he became hon. assistant surgeon, which office he held until 1890. In that year he was appointed to the full staff, fulfilling his duties until his resignation in December, 1906, on account of ill-health. He was then appointed hon. consulting surgeon. On his retirement the Weekly Board placed on record their high appreciation of the great services Dr. Brown had rendered to the institution. Dr. Brown for some time was house surgeon at the West London Hospital. He was also a demonstrator of anatomy at the Yorkshire College—now the Leeds University—subsequently being lecturer in clinical surgery. He became a Fellow of the Royal College of Surgeons, Ireland, in 1887, and M.Sc. (Leeds) in 1905. He was a medical referee under the Workmen's Compensation Act, and late hon. surgeon to the Leeds Public Dispensary. In March of 1905 Dr. Brown called the attention of medical men and the public to the dangers of the primula obconica, as illustrated by the death of a Leeds lady who, when recovering from an attack of influenza, accidently scratched her nose while smelling the flower, death ensuing within a week.

Dr. Brown was an ardent supporter of the Leeds Choral Union. From its inauguration he took a keen interest in the work of the society, having occupied the position of president. At the time of his death he was a vice-president of the union. Although taking little part in the public affairs of the city, Mr. Brown was a well-known figure. A man of striking personality and genial presence, he made many friends during his professional career, and his death will be mourned by all who knew him.

MALCOLM L. MARGRAVE, M.R.C.S., L.R.C.P.

We regret to announce the death from morphia-poisoning of Dr. M. L. Margrave. The news of his tragic death aroused deep sympathy in his native town of Llanelly, where he and his family are held in high esteem. The deceased gentleman was the youngest son of Mr. Robert Margrave, J.P. He was educated at Llandovery College, and thence proceeded to Edinburgh. He received his medical education at St. Bartholomew's Hospital, London. After acquiring his diplomas of M.R.C.S. and L.R.C.P. (London), he held the posts of house physician and house surgeon at the West London Hospital. After holding many and various appointments in private work, he travelled abroad, and for some time acted as surgeon in the service of the British India Steam Navigation Company, in which capacity he made several voyages to the East. He eventually settled down at Newton Abbott in partnership, and it was here that his health broke down. Later on serious heart mischief made its appearance, and it became imperative that he should seek a more bracing climate to live in. He was advised to remove to Scotland, and less than twelve months ago he went into practice at Moffat.

Apart from his purely professional attainments, Dr. Margrave was a man of wide culture and versatile talents. He was one of the finest tennis players in West Wales, and as an athlete generally he excelled. He was also a great reader, his knowledge of English literature being extensive.

CHARLES WILLIAMS, M.R.C.S., F.R.C.S.Edin.

We regret to announce the death of Dr. Charles Williams, M.R.C.S., F.R.C.S.Edin., who had for many years practised in Norwich, and at the time of his death was senior surgeon to the Norfolk and Norwich Hospital. Dr. Williams received his training at the infirmary in that city and at Charing-cross Hospital. He had an extensive private practice, and was consulting surgeon to the Norfolk and Norwich asylums. Dr. Williams was an authority on the life and writings of Sir Thomas Browne. He possessed a fine collection of early editions of Browne's works, and was the author of pamphlets on "The Measurement of the Skull of Sir Thomas Browne," "The Portraits of Sir Thomas Browne," "The Bibliography of the Religio Medici," and "The Pedigree of Sir Thomas Browne." He also published interesting facts about "The Treatment of the Sick in Norwich during the 17th century," and "The Barber Surgeons, of Norwich."

SPECIAL ARTICLE.

THE REPORT OF THE LOCAL GOVERNMENT BOARD FOR IRELAND FOR 1906-7.

Tuberculosis in Ireland.

The Annual Report of the Local Government Board, which has just been issued, supports very fully the opinion put forward by the Registrar-General with regard to the prevalence of tuberculosis in Ireland.

The present report dwells on the fact that in 1905 close on 12000 deaths in Ireland were due to tuberculous diseases, and particularly to pulmonary tuberculosis and that the death rate from this particular form of disease stands at a far higher figure in Ireland than in either England or Scotland. Referring to the feeling that has been aroused on the subject, the Local Government Board say that they are glad to state that the question has aroused very general interest, and that some of the sanitary authorities in and about Dublin, where the death-rate from tuberculosis is especially heavy, are taking steps to combine in a scheme for the establishment of a joint sanatorium for consumptives.

The Board fully recognise, they say, that it is a tedious and difficult task to secure co-operation among sanitary authorities for the establishment of sanatoria. The cost is for the most part too great to admit of one authority undertaking the erection of a sanatorium single-handed, and consequently a united district and a joint board of several authorities has to be constituted by Provisional Order, involving delay and considerable trouble in securing the consent of the various local bodies affected. On this point by way of a solution of the difficulty, the Local, Government Board say:—

"If the matter remains in the hands of existing sanitary authorities, a long period is likely to elapse before there is proper accommodation for the treatment of consumptives throughout Ireland. We consider, however, that many of the difficulties at present experienced would be overcome if power were given to County Councils to establish and maintain, either singly or in combination, suitable institutions for the treatment of consumptives."

The Board state further that in the opinion of their medical department the prevention of consumption should be dealt with on a systematic plan, consisting of these four elements:—

(1) Advanced cases should be accommodated apart in hospitals, the mere segregation of highly infectious patients from healthy persons being in itself a great safeguard against the spread of the disease.

(2) Where the disease is in an incipient stage and is capable of being cured or arrested, sanatoriums should be provided, where persons affected could be sent for proper treatment.

(3) In large centres of population, dispensaries where advice can be obtained, and where the latest methods of treatment can be tried, have proved very successful in other countries, especially in France, and might be established in Ireland with advantage.

(4) Lastly, local committees appointed by sanitary authorities to deal with the question of consumption would be very beneficial. The functions of such committees would be educative. They should endeavour to personally convey information to sufferers and also circulate leaflets and literature relating to this disease. Much might be done by active committees, who would advise their neighbours on the advantage of simple sanitary precautions in their homes.

Something more even than this, however, is needed in the opinion of the Local Government Board. They say, specifically:—

"We are of opinion that compulsory notification of pulmonary tuberculosis should be carried out by special legislation, and that safeguards should be provided to ensure that no unnecessary restraint is placed on the liberty of consumptive patients. If notification is used merely for the purpose of gaining information as to the locality of the disease, and helping the sufferer by giving assistance and advice, which would be useful in protecting other members of his family from contracting the disease, we consider that it would, under efficient and sympathetic administration, be a most useful public health measure."

The Board report that the Guardians of the South Dublin and Belfast Unions have shown a keen desire to improve and enlarge their accommodation for cases of consumption. The former, we are told, are making an extension of their female consumptive department for twenty additional patients. The Belfast Guardians it appears, have, during the past year, opened four pavilions at the Abbey Sanatorium, in which there were 112 patients on March 31st last, and the large hospital, which is rapidly approaching completion, will accommodate about 150 of the less hopeful cases. With the completion of this building, the Guardians will have spent about £34,000 on the purchase of the site and the erection of the buildings. The sanatorium will then have accommodation for about 265 patients with space for further extensions, which, however, will cost considerably less per bed, as the ground and the administrative arrangements are already provided.

Speaking generally of the country, the Board say that the subject of the treatment and segregation of cases of pulmonary tuberculosis in workhouse infirmaries continues to receive constant attention, and the nature of the disease being now more fully recognised, Boards of Guardians are evincing greater willingness to make provision for the care of patients suffering from it.

NEW PREPARATIONS.

ROGERS' MUSCATOL IN INSECT BITES.

Under the title of "Muscatol" Mr. Frank Rogers, the well-known chemist of Oxford Street, London, has introduced a pleasant preventive of insect bites. There is plenty of room for a good preparation of the kind, and Muscatol, so far as we have been able to judge, fulfils its purpose in a safe and efficient way. Who that has travelled would not often have given almost anything in his possession for a boon of this kind? Imagine what it would be to be able to defy the mosquitoes, say, when lying in harbour in Singapore, or in a West Indian port? Beyond the mere annoyance of mosquito bites there is, of course, the far more serious point of the malaria that is conveyed in that way. In future, however, the traveller or the sportsman can carry about with him protection in the shape of one of Mr. Rogers' bottles of Muscatol, sold at prices varying from a shilling to a guinea. It can be applied by a dropper or by a convenient little spray, and may be applied to clothing, bedclothes, or the skin-surface, generally or locally. If Mr. Rogers, by his timely remedy, can protect the patient fisherman at home and abroad, and the equally patient artist, from the bites of gnats and other noxious flies, he will be entitled the enduring gratitude of a great many of his fellow beings in all parts of the world.

BURROUGHS WELLCOME'S TABLOID "GINGA-MINT." (Soda Mint Compound.)

This new preparation of Messrs. Burroughs Wellcome, claims to be a valuable antacid and stomachic for the relief of dyspepsia, nausea, heartburn, and flatulence. It is said to promote appetite and digestion, while at the same time it relieves griping and produces a diffusible stimulant effect. The composition is as follows: Each contains sodium bicarbonate, gr. 5; ammonium bicarbonate, gr. 1-12; with gingerine, saccharine, and oil of peppermint.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

***Specially compiled for* THE MEDICAL PRESS AND CIRCULAR.**

RECENT SURGICAL LITERATURE.

The Treatment of Detachment of the Retina.—Professor Deutschmann (*Ophthalmoscope*, July, 1907) advises that operative treatment for detachment of the retina should be resorted to earlier than is usual, as much time is wasted in pacific treatment which gives such bad results. Prof. Deutschmann considers that his operative treatment gives better results than such procedures as (1) simple scleral or sclero-chorioidal puncture, or puncture of sclera with a galvano-cautery; (2) puncture of detached retina; (3) permanent drainage; (4) electrolysis; (5) intra-ocular injection of iodine; (6) cauterisation of sclera with or without sub-conjunctival injection of sodium chloride solutions. The author's operations are two in number. One he calls "bisection," the other consists of the injection of sterile animal vitreous body into the diseased eye. In performing the bisection operation, a double-edged knife is inserted tangentially to the globe downwards and outwards, passed horizontally across, making the counter puncture directly opposite, *i.e.*, downwards and inwards. The counter-puncture involves the sclera only, the conjunctiva being spared. In withdrawing the knife it is given a half-turn, which allows the sub-retinal fluid to escape. The eye is atropinised, and both eyes are bandaged for twenty-four hours, the patient being kept in bed seven or eight days. If necessary, the operation may be repeated in ten to fourteen days, and be done as often as ten or twenty times. The operation may be considered to be devoid of danger. The mischances one has to consider are the wounding of a large retinal vessel, or the lighting up of a previously existing inflammatory process. The injection of animal vitreous appears to be reserved for desperate cases, and need not be related here. M.

Scoliosis: Its Prevention and Treatment.—M'Ilhenny (*Lancet-Clinic*, July 20th, 1907) divides scoliosis into postural and structural. He believes that rickets holds a more important position in the ætiology of scoliosis than is generally conceded to it. The family physician is the person on whom the responsibility of preventing this condition rests, for it is he who has the opportunity to recognise deformities in their incipiency. The fundamental points in treatment are two: First, to correct the deformity and limber up the vertebral column as much as possible; and, second, to develop the muscles of the back so that they may be able to support the spine in the proper position. In the treatment of postural scoliosis, where no changes have taken place in the bones or soft parts, it is merely necessary to correct the faulty position and build up the weakened muscular system with massage and gymnastics without the aid of corsets or braces. Every case is first treated with hyperæmia. The patient sits with the back to a pentagonal cabinet which has an opening, oval in shape, cut in each side just large enough to allow the bared back to fit into it from about the sixth cervical to the fifth lumbar vertebra, and about three inches on each side of the spinous processes. In the centre of the cabinet there is a gas burner. The temperature is raised from 120° to 230° F., and the application lasts from fifteen to twenty minutes. After the patients have had the hot air application and their backs massaged for ten to fifteen minutes, they are then put through a course of simple gymnastics for half an hour. The less complicated the exercises are the better. The main point is to educate the body to involuntarily maintain the proper position. The treatment of structural scoliosis is more difficult as changes in bones, muscles, and ligaments have taken place, and motion is limited. While obtaining as much extension as possible in an extension frame, a plaster-of-Paris corset is applied. No padding is used, and the corset is well moulded over the hips and shoulders, the latter being incorporated. When the plaster sets the corset is cut down in front, removed and trimmed. When reapplied, it is laced up in front over shoe-hooks with elastic lacings, which causes constant pressure laterally. The author places a thin pneumatic cushion under the corset posteriorly, and one over the anterior opposite projection. By so doing the pressure on these parts is increased, and there is a tendency to untwist the rotation, besides correcting the lateral displacement. After the corset is finished the patient has a daily application of hyperæmia for twenty minutes, and then goes through the exercises. The first and most important exercise is a form of crawling on the floor, which is described in detail. The benefit of this exercise depends on the fact that when the limbs on one side of the body are well approximated in crawling, the spine becomes well bent with its convexity in the opposite direction. After the exercises the patient rests for twenty minutes in a correcting frame devised by the author. The corset is worn night and day for six weeks, being only removed for exercises and hygienic reasons. Fresh corsets are made about every two months with the patient in the best corrected position. These are used only during the day. It is a great mistake to keep a brace or corset on too long, for the muscles after a time rely on the artificial support, and atrophy consequently sets in. S.

Inoperable Sarcoma.—Coley (*Medical Record*, July 27th, 1907) makes a further report of cases successfully treated with the mixed toxins of erysipelas and bacillus prodigiosus. The author has himself successfully treated 42 cases, and 60 cases have likewise been successfully treated by other medical men. Of his 42 cases, 17 were round-celled sarcoma, 17, spindle-celled sarcoma, 2 mixed-celled sarcoma, 1 chondro-sarcoma, 1 epithelioma. In 4 no microscopic examination was made; yet the clinical features of the cases, such as recurrence after operation, rapidity of growth, size, and inoperability of the tumours, left hardly any doubt as to the diagnosis. The late results in these cases are as follows:—21 well from 5 to 14 years, 26 well from 3 to 14 years, 10 well from 10 to 14 years. Twelve cases are reported in detail. Coley finds that Dr. Tracy's method of preparing and standardising the toxin is the most satisfactory. It consists of: Streptococcus culture in broth, three weeks' growth 100 c.c. Prodigiosus suspension, containing 750 milligrams of prodigiosus proteid, 30 c.c. (sterilized one hour at 75°), glycerine, 20 c.c. After mixing and bottling the toxines the mixture is again sterilized two hours at 75°. One minim contains about 3 mgrs. of prodigiosus. It is most important in every case to begin with a very small dose, not over ¼ minim (diluted with a little boiled water to ensure accuracy of dosage). If the tumour in question is highly vascular it is wiser to begin the injections remote from the same, until the susceptibility of the patient to the toxins has been ascertained. As a rule, when giving injections into the tumour, only about one-fifth of the dose used for injections remote from the tumour is required to produce the same reaction. The best results are obtained by doses sufficiently large to produce severe reaction, say a temperature from 102° to 105°. The frequency of injection must depend entirely upon the strength of the patient, some being able to bear daily injections, while in others it may be unwise to push the treatment beyond three or four injections a week. In successful cases the effect is usually very promptly noticeable. The tumour becomes smaller in size, much more movable, and very much less vascular. These changes appear quickly, often within two or three days. The action of the toxins is both local and systemic. Sometimes the best results are obtained by giving injections alternately into the tumour and remote from the same. In intra-abdominal sarcoma, &c., a perfect cure may be obtained by systematic injections entirely.

S.

Partial Perforation of the Bowel Simulating Appendicitis.—P. Blumer records a case (*Lancet*, July 20th, 1907) of a coal worker, who, while pushing a heavy object with his foot, felt something give way inside himself, but for several hours felt no pain, then severe pain began in the right iliac fossa, the bowels acted, and the desire to pass water became very urgent, his temperature and pulse rate at this time were normal. On his admission to the infirmary a few hours later, he presented all the appearances of a man with an acute attack of appendicitis, temperature now being 102, and pulse about 80, he had no history of any previous attack of a similar nature. The pulse soon afterwards rising in frequency to 104, the abdomen was opened, and in the midst of a good deal of inflammatory lymph about the cæcum, a small tear of the muscular and serous coats of this organ was found. The lesion was about two inches from the butt of the appendix, and through the rent the inner coat was bulging out. The walls of the bowel were closed and the patient made a complete recovery. On account of the slight violence which caused the rupture of the bowel, and the close manner in which it simulated appendicitis, the case possesses considerable interest. G.

The Treatment of Suppurative Pyelitis by Lavage of the Renal Pelvis.—W. Ayeres gives an account of six cases (*International Jour. Surg.*, May, 1907) of pyelitis, which he had treated by local applications to the renal pelvis; in all the cases the infecting cause was the gonococcus. When no real kidney substance was felt, only slight improvement occurred, but when the suppurative process had only affected the kidney itself, to a small extent, rapid improvement or recovery followed. The solutions employed were argyrol and silver nitrate, the latter used at a strength of about 1 in 7,000, the ureter being catheterized through a cystoscope in the usual manner. Of these six cases two were failures, and nephrectomy had later on to be done, the remaining four were satisfactory, one being much improved and the other three completely cured. In one of these cases the flushing out of the pelvis of the kidney had only been done four times when all pus ceased coming from the ureter. In this case gonococci, although suspected, were not actually found, and this may account for the rapid cure.

G.

Renal Calculus: Its Etiology and Treatment.—P. Horowitz (*Post Graduate*, July, 1907), in a paper, illustrated by numerous cases, on this subject, deals very fully with the over-production of uric acid, drawing the following conclusions: 1. Renal calculus is the result of faulty metabolism. 2. The uric acid type, is the most common form. 3. The action of the calculus on the genito-urinary tract is purely mechanical. 4. Small loose stones in the pelvis and ureter cause the most symptoms. 5. There are cases of a single large stone occupying the pelvis and calices of the kidney without any symptom. 6. The most important symptoms are, pain, colicky in nature, starting in the region of the kidney or the loins, radiating down the ureter to the bladder and thigh, and to the penis and testicle in the male, and to the labia in the female. Hæmorrhage, beginning usually with the passage of the stone into the bladder, may be slight or excessive. Frequency of micturition, or occasionally calculous anuria. 7. The diagnosis is often uncertain unless the stone can be palpated, or be shown to be present by the X-rays. 8. Indican is an index to the condition of the digestion, therefore, pointing out the possibility of an existing suboxidation, and therefore the possibility of this condition being present also. 9. The Paquelin cautery is a valuable aid for relieving the congestion of the kidney, and thus aids in breaking up an existing anuria. 10. Carbolic acid stops the pain of renal calculus very quickly, and prevents recurrence by changing the over-produced uric acid into urate of sodium. 11. Attention to diet is of great importance in the treatment of renal calculus. Fruits must be excluded. G.

A Cause of Podalgia.—F. Bird, in an article illustrated by X-ray photographs (*Intercolonial Jour.*, June, 1907), gives an interesting account of four cases of podalgia, all of which had been treated by the ordinary methods without success, two of the cases were believed to be gout, yet on taking X-ray photographs of the os calcis in each case a spur-like process of bone was found growing from the under surface of that bone, the spur growing forward and running parallel with the sole of the foot; in one of the cases a similar process was found going on at the insertion of the tendo-Achillis. The author suggests that the condition present in these cases is a slowly progressing osteo-periostitis. There is no clear connection between these cases and cases of inflammation of the plantar fascia. In each case the same treatment was adopted, an incision made parallel to the sole of foot was carried down to the calcaneal tuberosity, the position of the bony spike having been determined by the finger a gouge was introduced and the offending portion of bone removed, the wound closed without drainage, the patient only kept in bed for three or four days. In all the cases the relief from pain was immediate, and has, up to the present, been permanent. G.

Rhinoplasty by Means of One of the Fingers.—Finney (*Surgery, Gynæcology, and Obstetrics*, July, 1907) describes the operation which he has performed successfully in two cases as follows: The ring finger of the left hand is selected. The nail and matrix are completely removed, the dorsum of the finger up to the distal end of the first phalanx denuded of skin. The top of the finger, throughout its entire circumference, is also denuded of skin for about the distance of 1 cm. from the end, leaving the distal phalanx exposed, but not completely so. The skin covering the nose which is retracted and deformed owing to cicatricial contractions, is then freed carefully from its attachments below without making any external scar. The skin of the nose is then stretched carefully and thoroughly. The soft parts are next freed from the nasal process of the frontal bone. The inner surface of the skin forming the nasal covering should be denuded on the inner side of the middle line, in order that a raw surface may be opposed to the denuded surface of the dorsum of the finger, which is now inserted into the nasal opening, until the tip of the distal phalanx rests upon the nasal process of the frontal bone. The finger is held in place by suture through the free border of the tip of the nose and the edge of the skin over the dorsum of the first phalanx. The hand is held in this position for two weeks, after which time the finger is disarticulated at the metacarpo-phalangeal joint and left for another week; at the end of this time the tissues over the nasal spine of the superior maxilla are split, and the finger flexed to a right angle at its proximal-phalangeal joint. The free end of the first phalanx is inserted into this opening and held there by stitches through the soft parts. The first phalanx forms the columna of the nose, while the second and third phalanges form a very satisfactory support for the dorsum. Later, smaller operations, under cocaine, are performed to improve the appearance of the columna. It is well as a preliminary operation to stiffen the last phalangeal joint of the finger in order to prevent a slight tendency to sagging of the bridge of the nose. S.

Medical News in Brief.

The King and India.

The India Office has issued the following letter which His Majesty the King has addressed to the Governor-General of India:—

Buckingham Palace, August 13th, 1907.

"My Dear Viceroy,—I have followed with anxious interest the later course of that epidemic of plague by which India has for eleven years past been so sorely afflicted.

"The welfare of my Indian subjects must ever be to me an object of high concern, and I am deeply moved when I think of the misery that has been borne with such silent patience in all those stricken homes.

"I am well aware how unremitting have been the efforts of your Excellency's predecessors and yourself to make out the causes of the pestilence and to mitigate its effects.

"It is my earnest hope and prayer that the further measures now being prepared by your Excellency in consultation with zealous and able officers, may be crowned with merciful success.

"I desire you to communicate this expression of my heartfelt sympathy to my Indian subjects.

"Believe me, my dear Viceroy, sincerely yours,
(Signed) Edward R. and I."

Progress of the Plague Measures.

A Reuter's telegram from Simla states that a Gazette Extraordinary has been published there, containing the above letter, and also a letter from the Viceroy to the local Governments and one from the Indian Government. The Earl of Minto states that the difficulties in the way of eradicating the plague are enormous, chiefly owing to the inability of the people to understand sanitary and hygienic measures.

In the third letter the Government of India states that the Plague Commission believed, first, that the bubonic plague is spread by rats; secondly, that the vehicle of contagion is the rat flea; and thirdly, that the life of the plague germ in soil, floors, and walls is of short duration. The Government recommend the destruction of rats, the improvement of the construction of houses, the reduction of the food supplies of rats by the protection of grain stores, the removal of people to temporary dwellings, and inoculation, while avoiding any action calculated to excite the opposition of the people.

Annual Dinner of the Caledonian Medical Society.

This Society met on August 1st in Bradford, under the presidency of Dr. Andrew Little, of that town. There was a good attendance from far and near. The membership, which consists of Highlanders, University medical graduates, now numbers 240, and they are spread all over the world. The great majority are graduates of Edinburgh. Glasgow and Aberdeen, in almost equal numbers, together furnish about half the membership, and there are a few from Oxford, Cambridge, and St. Andrews, and from the Royal University of Ireland.

The meeting took place at the Royal Eye Hospital, an extremely handsome and convenient building, of which Dr. Little is surgeon, and of which another Scot, Dr. John Bell, was founder. The latter it was who first declared that the "wool-sorters' disease" was due to a living germ, and made several valuable suggestions for its prevention, which were subsequently embodied in Acts of Parliament. He was also the pioneer of operation upon the eye for cataract and other diseases.

Sympathetic reference was made in the secretary's report to the deaths within the last few months of Dr. Alexander Macbain and the Rev. John Watson ("Ian MacLaren.")

The Dinner.

At the dinner in the evening at the Midland Hotel there was a large gathering of members and guests. The President proposed the loyal toasts. The toast of "The Caledonian Medical Society" was proposed by Dr. Swanson, of York, and responded to by Dr. S. R. MacPhail, of Derby; "The Universities," by Sir William Sinclair, of Manchester, and responded to by Dr. MacKenzie, of Burnley; "Caledonia," by Dr. Rabagliatti, of Bradford, who claims his Highland right because he is married to a daughter of the late Mr. Bright MacLaren, the well-known Member of Parliament.

Among other members present were:—Drs. Mackintosh, Stirling; MacGregor Sinclair, Burnley; Menzies, Mitchell, Dunlop, Munro, Clow, Beatton, Bonar, Gray, Hall, Baldwin, Dunlop—all of Bradford; Dr. MacGregor (a son of the late "Alastair Ruadh" of Inverness); Dr. MacNaughton, Stonehaven; Dr. Cameron Gillies, London; Dr. Stewart, Bacup; Dr. Blair, Lancaster; Dr. Bonner, Shipley; Dr. Angus, Bingley; Dr. Gordon Little, Blundellsands; Dr. Logan, Harrogate; Dr. Gairdner, Burnley; and quite a number of friends as guests.

The dinner was done in thoroughly good Highland form. There was a gorgeous piper, in the full Stewart dress of the old time. There was haggis and other things, and hearty good-fellowship.

Dr. Dunlop invited the members to his house, and among the relics exhibited was half a banner of the Clan Fraser that was at Culloden. The following is the history of this banner:—

"The complete colours were given to a Dr. Mackintosh, of Inverness, a great antiquarian, by the then Fraser of Lovat. In 1827 Dr. Mackintosh divided the colours into two parts—one he kept himself, and the other part, the history of which is now being traced, he gave to Mary Stewart, spouse to Dr. MacLaurin, of Culloden, Inverness, and afterwards of Bradford, Yorks. Mrs. MacLaurin died in 185-, bequeathing the colours to her daughter, Mary Miller, spouse to Jonathan Beattie, in 1883. The colours passed into the possession of their daughter, Agnes Paterson, spouse to John Dunlop, M.D., of Bradford.—(Signed), Agnes Paterson Dunlop.

"May 20th, 1883."

The motto of the clan is given in English, "I am ready," but only the letters "I am re—" are on this half. It would be interesting to know if the other half of the banner is in existence.

Presentation to a Medical Man

The guardians and officials of the Willesden Union have presented to their medical officer, Dr. Walter E. Turner, a handsome cabinet of table cutlery and fish carvers on the occasion of his marriage to Miss Jessie Powell, of Tregaron, Cardigan. Some of the inmates of the workhouse also presented the doctor with a beautifully-worked drawn-thread teacloth.

School of Tropical Medicine—Further Grant.

In the House of Commons on August 15th, Colonel Seely asked the Under Secretary for the Colonies whether, in view of the work already accomplished by the Liverpool School of Tropical Medicine in combating tropical diseases, he could arrange for an increased grant to be made in order that the work may be further extended. Mr. Churchill said a further grant will be made, of which the Secretary of State will be able to specify the amount after consultation with the Treasury.

NOTICES TO CORRESPONDENTS, &c.

☛ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

Dr. A. D.—The newspaper paragraph to which you draw attention is an advertisement in the worst possible taste. and for this reason cannot have been connived at by the physician mentioned therein. In all probability it is one of those unfortunate instances of journalistic irresponsibility, to which members of our profession are peculiarly subject.

G. W. M.—Your communication came to hand as we were "at press"; it will be duly considered before our next issue.

Docks.—It is a common mistake to attribute to Manson the original theory that the organism of malaria passed through the mosquito as its intermediate host. As a matter of fact, Laveran, who discovered the organism in 1880, formulated the theory of mosquito transference in 1884. But Sir Patrick Manson did more than anyone to keep the theory in being till its truth was demonstrated by Ross.

STATISTICS OF INDUSTRIAL POISONING.

Alien.—Regular returns are made monthly by the Home Office as to industrial poisoning and anthrax; they can be obtained from the Government printer. The returns for June last show that there were 48 cases of lead-poisoning and 4 of anthrax. Four deaths from lead-poisoning were also reported. Moreover there were 17 cases—with five deaths—from lead-poisoning in house painters. The figures for the first six months of the year are slightly better than those for the corresponding period of 1906, viz.:—1906.—342 cases of poisoning and anthrax, with 28 deaths, and 82 cases of lead-poisoning in painters, with 21 deaths. 1907.—261 cases, with 20 deaths, and 74 cases, with 22 deaths respectively.

Dubious.—The condition you describe has been called "Salaam Convulsion." It is not pathognomonic of any condition, for it occurs (besides in Spasmus Nutans) in epilepsy and Menières' disease, and is also seen in teething disturbances in rickety children.

DOCTORS HARD TO PLEASE.

"**Valetudinarian**" writes:—

"Having been under the care of doctors lately, I am told that if I wish to keep in good health I must follow these instructions:—

"'Eat only a light breakfast'; also, 'Breakfast should be the best meal of the day.'

"'Run or walk two miles before breakfast'; also, 'Never attempt to do anything on an empty stomach.'

"'Take a cold bath the first thing in the morning'; also, 'Remember the shock to the system of suddenly entering heat or cold is very injurious.'

"'Never use a pillow'; also, 'The most refreshing sleep is obtained when the head is elevated.'

"'Do not get into the habit of sleeping in the daytime'; also, 'Always take a nap in the afternoon.'

"'Eat only at meal-times'; also, 'Eat whenever you feel hungry.'

"'Get up at 5 o'clock every morning'; also, 'Sleep until thoroughly rested, no matter how late it is.'"—*News.*

Pater.—The average composition fee for the complete five years' course at a London hospital is about 130 to 140 guineas. This includes practically everything; but in event of failure to pass exams it does not always include second courses in practical classes. The fees may be paid in one sum, or in instalments, but the latter plan is rather more expensive. As a rule the fees for the London University classes run a little higher than those merely for the conjoint diploma. The difference averages about 10 or 12 guineas. Athletic subscriptions, instruments, books, dissecting parts are, of course, extras.

A Chemical Student.—In writing analytical reports, sometimes the volume percentage is desired, sometimes the weight percentage, and sometimes the percentage of alcohol expressed as proof spirit. As the great majority of alcohol determinations are returned as "by volume," except in the case of figures for the Inland Revenue, our reports are usually put in this form.

Vacancies.

Clifden Union.—Medical Officer. Salary, £140 a year, and £20 a year as Medical Officer of Health, together with Vaccination Fees. Applications to the Presiding Chairman, T. King, Clerk of Union. (See Advert.)

Royal Victoria Eye and Ear Hospital, Dublin.—House Surgeon. Salary, £40 per annum, with rations. Applications to E. Parker, Registrar. (See advert.)

Glasgow District Asylum.—Assistant Medical Officer required at Woodilee, Lenzie. Salary, £135 per annum, with board, lodging, washing, etc. Applications to the Medical Superintendent.

Bridgnorth and South Shropshire Infirmary.—House Surgeon. Salary, £110 per annum, with board and lodgings in the Infirmary. Applications to the Hon. Secretary, the Infirmary, Bridgnorth.

Birmingham General Hospital.—Receiving Room Officers. Salary, £150 per annum. Applications to Howard J. Collins, House Governor.

Egyptian Government.—Kasr El Ainy Hospital.—Resident Medical Officer. Salary £250 a year, with quarters, servants, washing, coal, and light. Applications to the Director-General, Public Health Department, Cairo

Egyptian Government.—Ministry of Education.—School of Medicine, Cairo. Assistant to the Professor of Pathology. Salary, £E.320 per annum. Applications to be addressed The Director, Government School of Medicine, Cairo, Egypt.

Worcester County and City Asylum.—Third Assistant Medical Officer. Salary, £140 per annum, all found. Applications to Superintendent Powick, Worcester.

Devon County Asylum.—Assistant Medical Officer. Salary, £140 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent, Exminster.

Prestwich, Manchester, County Asylum.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, furnished apartments, and washing. Applications to the Medical Superintendent.

Loughborough and District General Hospital and Dispensary.—Resident House Surgeon. Salary £100 a year, with furnished rooms, attendance, board, and washing. Applications to Thos. J. Webb, Secretary.

Aberdeen Provincial Committee for the Training of Teachers.—Lecturer on Hygiene. Salary £400 per annum. Applications to George Smith, Director of Studies, Training College, Aberdeen.

Manchester Township.—Assistant Medical Officer. Salary £110 per annum, with furnished apartments, fire, light, washing, and attendance. Applications to James Macdonald, Clerk to the Guardians, Poor Law Offices, New Bridge Street, Manchester.

London County Asylum, Long Grove, Epsom, Surrey.—Fourth Assistant Medical Officer. Salary £180 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, London Asylums Committee Office, 6 Waterloo Place, S.W.

County Asylum, Mickleover. Derby.—Junior Assistant Medical Officer. Salary £120 per annum, with furnished apartments, board, washing, and attendance. Applications to Dr. Legge.

Appointments.

Battersby, James, F.R.C.S.Eng., Lecturer on Anatomy in St. Mungo's College, Glasgow.

Danvers, H., M.D. Parma, L.R.C.P. and S. Edin., L.F.P.S. Glas., Assistant Physician to the Italian Hospital, Queen's Square, W.C.

Ellison, Francis Charles, M.D. Dub., Resident Medical Superintendent at the Mayo County Asylum, Castlebar.

Knox, Robert, M.D. Edin., M.R.C.S. Eng., L.R.C.P. Lond., Medical Officer in charge of the Electrical Department at the Great Northern Central Hospital

Muir, Gavin D., M.B., Ch.B. Glasg., Resident Medical Officer at the Royal Albert Hospital, Devonport.

Penny, Sydney Greenwood, L.R.C.P. Lond., M.R.C.S., Medical Officer for the Fourth District by the Penzance Board of Guardians.

Births.

Fraser.—On August 14th, at 36 Moray Place, Edinburgh, the wife of John S. Fraser, M.B., of a son.

Hay.—On August 15th, at Ancaster Drive, Anniesland, Glasgow, the wife of A. G. Hay, M.D., of a son.

Key.—On August 12th, at Valetta, Clarendon Road, Southsea, the wife of Aston Key, M.B., B.C., of a daughter.

Martin.—On August 16th, at 1 Marlborough Avenue, Hull, the wife of Edward Lister Martin, M.D., M.B., &c., &c., of a daughter.

Marriages.

Forrester—Hartnoll.—On August 14th, at S. John's, Potters Bar, Charles Carmichael Forrester, M.D., Public Health Department, Ministry of the Interior, Cairo, son of the late William Forrester, of Arngibbon, Stirlingshire, to Adeline Braund, youngest daughter of the late James Hartnoll, of Ganwic, Barnet.

Grayson—Walker.—On August 17th, at St John's Church, Burgess Hill, Lionel Dorrell, son of Francis Dorrell Grayson, M.R.C.S., of Rayleigh, Essex, to Gertrude Bardsley, daughter of the late Herbert John Walker, M.D., of Sheffield.

Deaths.

Adams.—On Aug. 15th, at The Lawn, Martock, Ernest Beadon Adams, M.R.C.S., L.R.C.P., Lond., late H.M.'s Colonial Medical Service, second son of J. Dixon Adams, M.D.

Coltart.—On August 17th, at Granville House, 714 Fulham Road, London, Joan Mary, infant daughter of Dr. and Mrs. Guy H. Coltart, aged 13 days.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

Abundant Precipitation.

THE almost phenomenal amount of cold and wet which have characterised this summer may have ruined the temper and holidays of a great many, but they have at least effected a vast saving of infant life. The experience of last quarter, when, to quote the picturesque terminology of the Registrar-General, "Precipitation was abundant," was very favourable as regards diarrhœa, the rate being 0.05 below the decennial average. But just as every Juliet is judged by her balcony scene, so every diarrhœa season stands or falls by its July and August performances, and as the returns come in these are seen to have been unusually benign. In some districts, indeed, the diarrhœa deaths have fallen almost to vanishing point; in Marylebone, for instance, there were only two for the whole of July, and in Leicester for the middle week of August only one. On the other hand, in spite of the weather, cholera appears to be rolling up in considerable force. It is taking its usual overland route, and having reached Southern Russia is spreading with considerable alacrity across the steppes. The usual sanitary cordons have been placed round the infected centres, but without avail, and the disease is making great progress. It is hardly possible that cholera will gain sufficient foothold in Central Europe to cause great devastation this year, as the season is too late, but had the temperature been at all propitious it might have reached Europe earlier and caused great havoc. So that there may be greater blessings than we are aware of disguised in the "abundant precipitation" we have so abundantly abused.

Pittsburg and Appendicectomy.

WE had occasion a few weeks ago to comment on the atrocious want of good form which distinguishes what passes for "society" in Pittsburg, as instanced by the giving of "whooping-cough parties," in which prizes were given to those who had the most severe paroxysms or made the loudest noise. They seemed to us far more vulgar than the game that gutter-urchins indulge in, of seeing who can spit the furthest. The great ladies of Pittsburg are *nouvelles riches* in the most odious form, namely, that of trying to outdo the extravagances of the most *outrée* of their kind. The last report is that these gentle creatures, being tired of the usual excesses, decided by way of deriving a new sensation to have the appendix vermiformis removed. Last month eighty-four of the "leading society women" of that town accordingly had the operation carried out, although there was no surgical need for it, and their medical advisers were strongly opposed. The astonishing thing is that surgeons were found to perform a merely mutilating operation of the kind, but presumably a demand creates a supply, and money seems to be able to buy anything in Pittsburg, except good taste. It seems almost a pity that all the unavoidable fatalities of appendicectomy over a suitable period were not crowded into these eighty-four operations.

A Royal Order of Motherhood.

DR. RENTOUL, among reformers, possesses the invaluable quality of imagination, and he now comes forward with the suggestion that in order to encourage the rearing of children the Queen should institute a Royal Order of Motherhood, to be awarded to those women who have the largest and healthiest families. It certainly seems reasonable that as decorations and knighthoods galore are given for the destruction of human life, a little reward should occasionally reach those who devote themselves to its creation and nurture. True, there is the King's Bounty for triplets, but after all the bearing of triplets reflects but little glory on the mother, and for State purposes these pleonastic births are of little use, as the infants almost invariably are puny and not infrequently die within a few hours. In these piping times of peace and International Congresses, the slaying of men is happily a less popular and lucrative trade than of yore, and, contemporaneously, but perhaps not etiologically related to this decline, is the fall in propagation of mankind, so that it might be well to make the begetting of children as honourable a business as the slaughter of adults. Both are ancient and popular pursuits, and the former has the additional recommendation of economic utility.

Triplets and Trouble.

THE death of triplets caused an interesting point to arise at Barnes last week. A medical man, Dr. H. P. Daniell, attended a woman who was confined of triplets. One of the children was born dead, and the other two died shortly after birth. Not being satisfied as to the cause of their sudden deaths, Dr. Daniell declined to give a certificate, but he wrote on a piece of paper the fact that the children died shortly after birth.

This document not being a valid certificate, as indeed it was not intended to be, the children could not be buried and, as the result of the pother that ensued, Dr. Daniell was summoned on no less than six charges by the Registrar-General for unlawfully refusing, without reasonable excuse, to give a certificate. Counsel for the prosecution, after giving his version of the affair went so far as to state that Dr. Daniell was trying to get money out of the affair by making post-mortems on the three children and giving evidence at three inquests. What evidence there may have been on which to rest this charge the prosecuting counsel did not call, and as it was shown that when interviewed by the coroner's officer and told there was to be no inquest, Dr. Daniell still refused to give a certificate it may be taken that there was pretty cogent evidence against the suggestion. The evidence that the prosecution called, namely, that of the coroner and the police surgeon who had viewed the bodies was to the effect that there was no reason from what they knew of the circumstances to suspect foul play, and Dr. Daniell, simply stated that he did not know why the children died and therefore proceeded to throw the onus on the coroner.

Opinion and Practice. Now, as a medical man is required to state on a certificate what in his opinion is the cause of death, it is obvious that if he has no opinion he cannot certify. In practice when a medical man has no reason to suspect foul play he usually fills in a certificate to save his patients the pain of an inquest, but this position is a compromise with the very bad law regarding certification. Not only is the law bad, but it is also both mean and harsh, for besides providing no payment for the medical man's opinion, it penalises him if he does not certify. And it is still more illogical in not precribing any procedure in the case of a medical man being unable to certify. Again, what happens practically is that a medical man usually writes an unofficial note to the coroner, but this he is by no means bound to do, and certainly the State has no right to expect it of him. It is such distasteful work to quarrel with forms and ceremonies in connection with death that medical men have long suffered under this unjust law, when all that is necessary to correct it is a general refusal to give information.

Law and Logic. DR. DANIEL has stood on his strict rights, and his action has given the authorities some trouble; he has, therefore, been subjected to the ignominy of police-court proceedings in order, as they would probably say, "to bring him to his senses." As a matter of fact the people who need bringing to their senses are those who frame unjust laws and administer them by inquisitorial methods. In the case in question there were two magistrates on the bench and they disagreed in opinion, so that the case is one which obviously presents complex issues, and when one reflects that hundreds of persons, principally children, are buried every year without certificate and without inquest, the farcical nature of the whole administration of the law is at once revealed. Attempts are made to bully and cajole medical men, after giving the State free information, to make them give it in certain words most convenient to the Registrar-General. In fact registrars often make great difficulty about accepting certificates except according to the nomenclature of the College of Physicians, and to save patients annoyance medical men have to submit to this slight. As the Registrar-General is paid a handsome salary and given a large staff to assist him, any difficulty in the classification of a death should certainly fall on him, and not on a private practitioner, who has already given more information than can reasonably be expected from him.

LEADING ARTICLES.

THE RATIONAL ECONOMY OF SANATORIA FOR CONSUMPTIVES.

THE slow and gradual evolution of public health matters is apt to discourage scientific enthusiasts who devote their energies to that particular field of work. The old proverb which reminds us that "Rome was not built in a day" applies with emphatic point, *mutatis mutandis*, to the practical adoption of fresh truths into our national system of sanitary administration. Take the case of consumption, the study of which was first placed on a sound scientific basis by the demonstration of its specific pathogenic organism by Koch in 1882. Twenty-five years have elapsed since the announcement of his great discovery, and the whole question raised thereby has been the subject of universal interest. It may safely be said that no matter in the whole range of medical affairs has received a greater amount of serious discussion, both inside ond outside the profession. It has taken more than a quarter of a century to decide authoritatively that bovine and human bacillus tuberculosis are identical. As a corollary it has taken an equal period of time to arrive at the conclusion that infected milk must henceforth be regarded as the probable source of much of the terrible incidence of tuberculosis upon our infantile population. That result, it must be acknowledged, has been arrived at short of actual practical demonstration of such transmissibility. The slow incubation of the disease and the difficulty of establishing adequate and absolute proof of infection in individual cases render the application of any direct logical processes well nigh hopeless. There are sufficient data, nevertheless, to enable us to form a reasonable inference as to which direction will be taken by the balance of probabilities. Given a specific bacillus shown to exist in man and to be extremely prevalent in cows, the milk of which is infected thereby; given the use of cow's milk as the staple food of infants and children; and given the existence of a terrible mortality from tuberculosis amongst the infantile population; then it is not altogether unreasonable to assume that the bacillus in the cow is more or less answerable for the disease among children. That assumption, at any rate, appears to afford the best explanation that can be framed in our present state of knowledge. It is open to those stern logicians who demand more stringent logical proof of the relation of cause and effect in this particular case to advance a more probable and a more convincing working theory, that will be more in consonance with the facts so far as they are known to us. Meanwhile, the recognition of the infectivity of phthisis has led to a great diminution in the disease; whatever doubts may surround etiology, there emerges the distinct and gratifying fact that modern science is gradually ousting the malady. At best, however, the campaign is slow and protracted, resembling the ancient wars that lasted for many years rather than the sharp contests of modern warfare. It may be said that one great and sweeping strategic movement will consist in the eradication of tuberculous meat and tuberculous milk from our food supplies. In any case, it is tolerably safe to assume that the actual cure of consumptives will play a comparatively small part in the ultimate eradication of the disease, which is the only permissible goal of the scientific sanitarian. Nevertheless, on humane and other grounds, it is clearly the duty of society to neglect no means whereby the disease may be held in check, especially amongst our working-class population. Among the practical achievements of which the past quarter of a century has reason to be proud is that of the open-air treatment of consumptives. In the attempt to render that method available, huge sums have been spent on special sanatoria. After the lapse of a few years it seems likely that the erection of costly buildings for the purpose is already obsolete as a practical scheme. In one notorious instance the prime cost has reached as much as £1,000 per bed, and even then only a minimum of gratuitous relief is available. A correspondent to a London newspaper recently showed that a serviceable garden bedroom, constructed on three sides by matchwood boarding covered with tarpaulin, and on the fourth by a blind, could be constructed at a cost of £2. Instead of a bed costing £1,000 it would be simpler to erect 500 beds at £2 each, and to devote the interest on the vast capital sunk in founding the remaining £1,000 beds in providing a medical, nursing and commissariat staff and the necessary maintenance of patients. Even now the mistake of the big sanatoria might be to some extent remedied by selling them for other purposes, and then devoting the purchase-money to sanatoria on more economical and rational lines. The main curative problem is to get at the working-man consumptive in the early stages of the disease, and to restore him as an effective worker in the industrial army.

MR. JOHN BURNS ON THE NOBILITY OF THE MEDICAL PROFESSION.

THE notification of the Births Bill passed its third reading in the House of Commons on Friday last. As many of our readers know, the measure is in the charge of Mr. John Burns, President of the Local Government Board. The intention of the Bill is sound enough, inasmuch as it aims at securing an important administrative return. Incidentally, however, it throws upon the medical profession a new duty, as recently insisted upon in our columns, without providing for the payment of any fee. More than that the Government has now actually made it penal for medical men to refuse to discharge gratuitously the responsible service thus thrust upon them by the State. The legislature has in this way marred the statute book with a monstrous violation of the rights of an honourable profession. In refusing the amendment which would have freed medical men from the obligation to sign such a certificate Mr. John Burns made some remarks that are worthy of attention as showing the characteristic attitude of legislators with regard to our profession. He said in effect that it was a matter of extreme regret to him that a great, honourable and charitable profession should have practically dissociated themselves from what he believed to be one of the most beneficient movements of recent years. Let Mr. Burns compare a parallel case. Criminal law reform may be described equally, if not far more so, as one of the most beneficient movements for the proper administration of justice in this country that has been witnessed for centuries. Would Mr. Burns on that account ask the lawyers to undertake important professional duties imposed by a new Criminal Law Reform Act without fee or reward? We trow not. The lawyers in and out of the House would treat the suggestion as a farcical joke. Why then should Mr. Burns seek to exact the rendering of responsible legal documents gratuitously from another learned profession? Medical men cannot live on honour and charity alone, and it is precisely in ratio to the loftiness of their principles and of their lives that the Government should consider the question of their remuneration for services rendered to the State. At present the Government exacts much money and many stringent conditions in return for a legal medical qualification. It then abandons the duly qualified practitioner to the unrestricted competition of every quack and charlatan who chooses to batten on the community. Of all men we should have thought Mr. John Burns the first to concede the principle that the labourer is worthy of his hire. Possibly he has grown so accustomed to the generous prodigality of medical science that he regards it as fair play to any Minister wishing to carry out his measures economically. However, as the Bill now stands, medical men will be subject to prosecution for refusing to sign a gratuitous birth certificate. The thanks of the profession are due to Dr. Cooper, M.P., who fought their cause in the House, and we only regret he was compelled to withdraw from the position of demanding fees for the signature of the certificates in question. If lawyers had such a duty thrust upon them they would probably resist, to a man, and it is a question how far the doctrine of passive resistance might be accepted by the medical profession with advantage in this and other matters.when their corporate rights are threatened and invaded. The Government could hardly complain if medical men throughout the kingdom refused to sign certificates forced on them under such conditions.

CURRENT TOPICS.

Typhoid Epidemic at Peterhead.

PETERHEAD has been for some time past in the throes of an epidemic of enteric fever. Fortunately it appears to be on the decrease, as the last weekly report shows eleven cases as against twenty-four for the preceding week. The total number of cases at that time was 341, which is a somewhat serious percentage of a population returned as 13,674. An investigation has been made by Dr. Matthew Hay, of Aberdeen. From his interim report it appeared that the origin of the epidemic lies in the water supply. It seems that the sources were subject to considerable pollution at the time when the outbreak begun and from the report it is clear that a great deal remains to be done before the supply can be regarded as safe. The incident emphasises the need of unrelaxing vigilance in the control of a water supply from its sources and all along the line. Neglect of this supervision is apt to be followed by a terrible nemesis in the shape of sickness, death and commercial disaster to a whole community. One of the clearest lessons of modern sanitary science is the absolute need of the provision and maintenance of a pure water supply.

Mr. Gladstone and Alcohol.

THE perennial problem of " doctors and drink " —as the lay journals tersely dub the topic—receives day by day fresh and amusing comments from newspaper correspondents. Recently one writer said that Mr. Gladstone was often a great deal at his father's house, and one day, then a boy, leant over the dinner table and said to him, " There are few things better in this world than the pint glass of champagne on a hot summer's evening." He gently hints that the great man's first was not his last, and was eked out later with two or three glasses of port, not light port from the wood, but heavy vintage wine of 1863. This interesting bit of biography will be held by many moderate drinkers to afford pretty strong testimony to their view of the case, namely, that alcohol in reasonable quantities is consonant with the highest sustained intellectual and bodily fitness. Not so with the narrator of this incident, who remarks that " it is positively appalling to try to conceive what Mr. Gladstone one of the giant intellects of his own or any other age, and one of the strongest men physically, might not have done had he not poisoned both his mind and body consistently during his long and active life." This attitude reminds one of the gentleman who informed a teetotal audience that he had smoked and drunk all his life and was still hale and hearty at ninety-six years of age, when the lecturer retorted there was no knowing what age he would have reached had he not " tasted the poison at all—at all."

Death from Easton's Syrup.

A RECENT prosecution, instigated by the Pharmaceutical Society under the Sale of Poisons Act, deserves the attention of medical men, inasmuch as it calls attention to a risk that would otherwise hardly receive attention. The defendants were " Boot's, described as Cash Chemists," who sold a bottle of tablets of " Easton's Syrup " to a customer without making any entry in the poison book, although each tablet contained 1-64th of a grain of strychnine. By some inadvertance the bottle got into the hands of a baby, who swallowed about seventeen tablets and died in half an hour. The manager of Boot's admitted that two such bottles would contain enough strychnine to kill a man. A fine of £5, with 25s. costs, was inflicted. Now that the danger has been pointed out it is probable that chemists will take care to impress their customers with the nature of such a preparation. It seems still more likely that the manufacturers of the tablets will cease to put up the drug in tablet form, especially as there seems to be no particular advantage over the fluid form in which it is usually prescribed.

Urticaria and Military Service.

THE subject of urticaria, owing to the recent prominence in a London police court, is likely to leap into considerable prominence in the medical world. Without in any way discussing the legal issues involved it may be interesting to call to mind some of the chief facts of the malady in relation to the physical disability or otherwise of the sufferer. The origin of the affair was the prosecution of a Birmingham Yeomanry trooper for absenting himself from the annual training. He was arrested and brought to London under military escort, and when brought into Court presented the magistrate with three medical certificates, stating he was unfit to attend the training on account of urticaria. The medical officer of the Yeomanry suggested that the malady in question was not serious enough to warrant defendant's absence. Owing to the cost of bringing the medical witnesses from Birmingham the defendant's side of the question was not supported medically at the first hearing, but the magistrate adjourned the case so that the evidence of the signatories could be obtained. When the case was heard again the defendant's case was supported by three medical men, one of them being a well-known Birmingham dermatologist, and the magistrate, in view of their evidence, could only find that the trooper's absence was justified. There is, of course, urticaria and urticaria, but few who have seen a really severe case with its attendant fever, prostration, vomiting and general misery, would wish to see the patient on horseback playing the part of one of the Empire's defenders.

Infection from Old Bottles.

A point of some importance was raised by a deputation from the National Glass Bottle Hawkers' Trade Union, which recently waited on the President of the Local Government Board, with the object of directing the attention to the danger to public health involved in the indiscriminate use of old bottles. There is little doubt that bottles collected from ash-pits and other unsavoury surroundings, are, with no more than a perfunctory cleansing, again put to use. It is not improbable too that bottles from the sick-room of an infective patient are occasionally returned to the druggist for re-filling without sufficient disinfection of the exterior. In this way infection is liable to be carried from the sick to the healthy. It is doubtful whether the interference of the Local Government Board in the matter would be likely to result in any good, but the deputation has done useful work in drawing public attention to a possible danger. The cleansing of a glass bottle is, in most cases, a sufficiently simple matter, and when any difficulty presents itself, it is better that the bottle should be destroyed than that any risk should be run.

The Cardigan Cancer-"Curers."

AN interesting but rather odd article on the Welsh Cancer-"Curers" appears in the current number of *The Crown, the Court and Country Family Newspaper*. It is from the pen of Dr. W. R. Hadwen, and its curious nature consists in this that while it contains mainly facts and opinions which form a ruthless *exposé* of these persons, at the same time they themselves are throughout spoken of in terms of toleration, if not of indulgence. The brothers are no doubt enthusiasts, especially the elder, Daniel, but if men are so blinded with enthusiasm for their own gain as to cause intense unnecessary suffering to people, it becomes the duty of the Public Prosecutor to proceed against them. There are certain kinds of barbarous enthusiasm with which the State becomes intimately concerned, and even in India and Africa cruel native customs which are part of their very religion are suppressed. The tale told by Dr. Hadwen is a ghastly one. These brothers, glutted with semi-religious fervour, but jealously guarding their precious "secret"; crowds of wretched sufferers tortured with the pangs of cancer enhanced by the "remedy"; dead and dying and suffering from every country of the globe, in every quarter of the little town; sufferers with awful wounds sent home as "cures" when their patience, money, or credulity has given out; cancer diagnosed in every case and whole organs charred in the caustic application; and an analysis of the "Secret Oil," which was obtained from part of an eschar, and found to be composed of zinc chloride with traces of arsenic and antimony. There are some hundreds of these wretched patients, and applications are pouring in every day from fresh ones, while money seems to be rolling in on every side. We ask, in the name of good government and common humanity, if this state of affairs does not form a *prima facie* case for the attention of the Public Prosecutor.

Roof Gardens.

ONE of the penalties paid by mankind for the privilege of living the corporate life of great cities is the excessive value attached to the necessarily limited land area. All sorts of shifts are adopted in order to make the most of an available area. The most obvious is to build skywards, on the plan adopted in ancient walled cities. Another is to burrow beneath the earth's surface, as in the case of the tube railways. One of the most recent movements is to utilise the roof tops, after the manner of some Eastern countries. There is no particular reason why a hanging garden should not exist on most of our modern roofs, provided always that the jerry-builder has not been concerned in providing walls unequal to any additional strain. Where gardens are not adopted it would be feasible to erect glazed conservatories for recreation purposes. Sir Lauder Brunton, who advocated this departure at the recent Housing Congress, put the matter in a nutshell when he said that our roofs should be flat instead of sloping, "terraced, with covered parts to shelter from rain and sun, and with walls high enough to prevent accidents." As a matter of scientific fact, the air at the level of roofs is purer than that of the roadway in direct proportion to the altitude.

PERSONAL.

THE PRINCE OF WALES, as Grand Prior of the Order of St. John of Jerusalem, has awarded the gold medal of the Order to Dr. Albert von Lecoq, of Berlin, for marked heroism during attendance on an English officer in Turkestan.

WE are asked to announce that H.H. Prince Henry zu Schönaich-Carolath has consented to act as president of the fourteenth International Congress of Hygiene and Demography. Dr. Rubner, Privy Councillor of Medicine, Professor of Hygiene at the Royal University of Berlin, and Professor Dr. von Mayr, Under-Secretary of State, Munich, will be vice-presidents.

SURGEON-LIEUT.-COLONEL C. R. KILKENNY, C.B., Medical Superintendent to Officers' Convalescent Home, Osborne, Isle of Wight, has been appointed a Member of the Fourth Class of the Royal Victorian Order.

LIEUT.-COLONEL JAMES WISE, R.A.M.C., Principal Medical Officer, has been appointed an Official Member of the Legislative Council of the East African Protectorate.

DR. OLIVER C. MAURICE, Consulting Surgeon, to the Royal Berks Hospital, Surgeon to H.M. Prison, Reading, whose death was recently recorded in these columns, has left estate valued at about £26,000.

A TESTIMONIAL is to be presented to Mr. John Carswell as a mark of sympathy with him in the recent attack made by a lunatic whom he had recently certified. The honorary treasurer is Mr. Nicoll, City Chamberlain of Glasgow.

ANY friends of the late Major D. M. Moir, professor of anatomy at Calcutta, wishing to subscribe to a fund now being raised for a memorial are requested to communicate to Captain F. R. Connor, I.M.S.. or to Rai Bahadur Dr. Hira Lal Basu, the honorary secretaries.

WE regret to learn that Dr. D. Nicholson, C.B., a Lord Chancellor's Visitor in Lunacy, has sustained considerable injuries in a cab accident. Dr. Nicholson is progressing favourably.

A CLINICAL LECTURE

INFANTILE DIARRHŒA.

By G. F. STILL, M.A., M.D., F.R.C.P.,

Professor of Diseases of Children, King's College, London.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

I HAVE chosen rather a hackneyed subject for my lecture this afternoon, but it, at any rate, possesses the interest which belongs to the commonplace, for I suppose all of us are concerned at some time or other in dealing with the dangers and difficulties of infantile diarrhœa.

In the first place, let me show you some statistics which emphasise certain points of practical importance.

	DEATHS FROM ALL CAUSES IN LONDON.			DEATHS FROM DIARRHŒA IN LONDON.		
	Total under 1 year old.	Under 3 months.	3 months to 6 months	Total under 1 year.	Under 3 months	3 months to 6 months
1891	20,776	9 662	4,286	2,272	608	742
1892	20,441	9,614	4,162	2,340	745	845
1893	21,814	10,282	4,752	3,265	953	1,144
1894	18,812	9,083	3,680	1,866	518	620
1895	22,252	10,091	4,755	3,803	1,024	1,282
1901	19,678	9,565	4.113	4,029	1,071	1,383
1902	18,307	8,927	3,545	2,542	590	859
1903	17,223	8,594	3,463	2,818	729	981
1904	19,012	9,050	3,948	4,408	1,076	1,474
1905	16,603	8,253	3,224	3,347	869	1,092

Notice that there are between 2,000 and 4,000 deaths annually in London under the age of one year from infantile diarrhœa, and that the number, so far from diminishing during the past ten years, has rather increased. The series of years I have taken at random. It may be objected that there is a possible fallacy, namely, that a larger area may be included under the term London in one period than in another; but this fallacy is avoided by regarding the proportion of deaths due to diarrhœa relatively to those due to all causes. In 1891, nearly one-tenth of the deaths under one year of age were due to diarrhœa. In 1901, the fraction rises to one-fifth, or twice the relative number. This fact has a practical bearing. We hear a great deal about the advances which have been made in regard to sanitation, about municipal milk depôts, and so on; but it is clear, in spite of all boasting to the contrary, that the cause of infantile diarrhœa remains, the mortality from that disease has increased instead of decreased; the reduction of the infantile diarrhœa mortality calls for some other remedy besides improvement of the milk supply and of the methods of artificial feeding. This table shows a striking difference in the proportion dying under three months compared with those between three and six months, the latter being always the more numerous. In 1891, 9,662 died from all causes under three months of age, and out of that number 608, or one-sixteenth, died from diarrhœa. In the same year there were 4,286 deaths between three and six months from all causes, and 742 in the same age period from diarrhœa—or about one-sixth. At first sight this appears contrary to all we know as to the liability to diarrhœa and its danger at those ages. We know from clinical experience that the infant under three months old who has diarrhœa is in much greater danger than is a baby between three and six months old; yet the number of deaths is much less at that age. The explanation is obvious: that the infants under three months old are breast-fed for the most part; but breast-feeding is progressively less frequent as the infant becomes older. There, I take it, lies the key to the reduction of infant mortality in this country, the encouragement of breast-feeding and the instruction of mothers as to the importance of suckling their infants as long as possible. This is being realised more and more by the people, and among the hospital class the advice which has been steadily tendered at children's hospitals is bearing fruit. The paramount importance of breast-feeding comes out very strikingly from statistics of the fatal cases. I investigated cases at the Children's Hospital, and found that 96 per cent. of the infants who died of infantile diarrhœa were hand-fed; 92 per cent. out of the 96 per cent. were hand-fed entirely, the remaining 4 per cent. had had both kinds of feeding. Only 4 per cent. of the deaths from this disease were in children who had been entirely breast-fed. So breast-feeding, or even partial breast-feeding, is the great safeguard against diarrhœa.

Now let me draw your attention to a very practical point, which is not generally realised, namely, the part played by condensed milk in the causation of infantile diarrhœa. I have been told by practitioners that they order condensed milk because it is sterile, and therefore so much safer. But so far from this being true, condensed milk seems to be particularly dangerous, and the child who is taking it runs a special risk of having summer diarrhœa. I have kept a note of the feeding of a large number of babies, and I find that 12 per cent. of infants brought to hospital had been fed upon condensed milk, whereas of the fatal cases of diarrhœa, 25.8 per cent. had been fed upon condensed milk.

The mode of feeding is not the only factor in the production of this disease; temperature is also important. And if this is so, we may expect a reduction in the mortality this year. I show you a chart, based upon the Registrar-General's returns of deaths, and the Greenwich Observatory records of temperature, *i.e.*, the mean weekly temperature. At first glance, the curves do not seem to agree, but on closer inspection they do so fairly closely. The rise in the temperature curve naturally precedes by three or four weeks the rise in the death curve, because the disease takes some time to kill—usually three or four weeks.

What is the connection between high temperature and infantile diarrhœa? Clearly it is not the heat alone which increases the death-rate, or

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(a) Delivered at the Medical Graduates' College and Polyclinic, July 9th, 1907.

breast-fed children would suffer equally with the others, but they do not. It has been supposed to be due to the growth of some bacterium which is present in the soil, and Ballard published some observations in support of this view; but there has been no proof of it in bacteriological research since. There is the obvious suggestion that it is something carried by milk, but we have no proof even of that. Several bacteria have been described, within recent years, as the cause of infantile diarrhœa, but none of them have been shown to exist particularly in the food which the infant takes. Another possibility is that the bacteria which cause the disease are normal inhabitants of the intestine and only become pathological under certain conditions—that when an irritating food is given repeatedly to a child the intestines become much more liable to invasion, and permit of a rapid growth of bacteria. As an American writer puts it: repeated insults to the intestine make it particularly susceptible to bacterial invasions.

Some reference I must make to the classification of diarrhœa, because it has some bearing on treatment, and it is of treatment I wish particularly to speak. All sorts of elaborate classifications have been suggested, some based upon bacteriological grounds, some upon clinical observation, and some upon morbid anatomy. Many of those given in text-books are of but little value for clinical purposes; they assume more than we know. I think the simplest way is to divide them into two, or possibly three, groups:—(1) Simple gastro-intestinal catarrh, which some people call "intestinal dyspepsia," that is, simple diarrhœa due to some faulty food. (2) The more severe form known as gastro-enteritis with ileo-colitis, in which there is a rise of temperature possibly due to some infection. It includes "summer diarrhœa" and "febrile diarrhœa." (3) The most severe form, known as cholera infantum, in which the child, in twenty-four hours, is almost moribund. I doubt very much whether even such a classification has any really solid ground to rest upon. It amounts, after all, to little more than a distinction of degrees of severity. It is often impossible to distinguish between gastro-intestinal catarrh and gastro-enteritis. I have no doubt there is a difference between the simple diarrhœa in the child whose food is indigestible, and the severe diarrhœa which comes on in the middle of summer. But there are cases in which it is difficult to draw the line; they seem to merge the one into the other. I do not know of any proof that cholera infantum differs from severe gastro-enteritis, except in the "rice-water" stools, and the fulminating course. Until we know a difference in ætiology, our distinctions are somewhat premature. However, the treatment of some of these conditions differs from the treatment of others. You may be able to say that in one child the lower part of the intestine is affected more than the upper, although you may not be able to say what the change is. You know that the child's colon is distended and that it is passing much mucus and streaks of bright blood in the stools, and that it suffers from tenesmus, and gets prolapse, and you are justified in supposing that there is some colitis or ileo-colitis. Another child may not be passing either blood or mucus, but vomits and has loose watery stools. We say such a child has gastro-enteritis, and the treatment will differ correspondingly.

I have not time to say much about the complications of infantile diarrhœa, but one which is very apt to be overlooked is otitis media. In all acute diseases of infancy and early childhood, this is a very common complication, and the symptoms are often wrongly interpreted. The infant suffering from diarrhœa begins to scream and the screaming is supposed to be due to pain in the abdomen, but it is not, and in a few days the child is found to have a discharge from the ear. Such a child may have head retraction, and other symptoms reminding one of meningitis. These have been verified at autopsies as due to ear mischief; there is not necessarily any discharge from the external ear.

Now with regard to treatment, for that is my main point: I suppose there is scarcely any disease for which more methods of treatment have been suggested, yet in very few diseases is it so difficult to decide what method of treatment is likely to suit in a given case. Let me first venture to find fault with what has sometimes appeared to me to be a shortcoming in the treatment of these cases. The practitioner, when called in, finds the child very bad; he orders some medicine, and says he will call again to-morrow. But infantile diarrhœa acts so quickly that the case may have slipped through his fingers before the next day; such a child should be seen, if at all possible, three or four times a day. In the simple gastro-intestinal catarrh, little is necessary beyond an aperient to clear the bowels, and I know of nothing so good for this as the old-fashioned castor oil, which has the advantage that its subsequent effect is to constipate. The food may require to be made a little weaker, and it may be advisable to give opium.

It is the severe forms which are difficult to treat, and, as the feeding is of prime importance, I shall consider that first. It is poor economy to attempt to feed these cases with milk diluted or modified first this way and then that. It is better to stop milk altogether at the outset; no ground is lost by so doing, for the infant does better by retaining even plain water than by having its vomiting and diarrhœa prolonged, or possibly aggravated, by some form of milk feeding. What, then, is to be substituted for milk? I put them down in the order of strength. First, veal or chicken broth (I believe these are preferable to mutton broth); next I put various cereal decoctions. Rice-water is more likely to suit than barley water. Let an ounce of rice soak for three hours in a quart of tepid water, then boil for an hour, then strain. Next I put albumen water—ordinary white of egg water. Next, something which is much used on the Continent for infantile diarrhœa, though only rarely here—extremely weak tea. At a hospital in Germany I was told it was given because the tannin had an astringent effect on the intestine; in another, that it had a stimulating effect. At any rate, it has been found useful. Lastly, there is plain water, on which a child will live for many hours, and if difficulty is found with albumen water, this is the wisest thing to give.

When the vomiting begins to subside, you can reverse the order, until finally you get back to the broth. Next to broth, on the return journey, the best thing is whey. I did not mention in this connection with the treatment of the diarrhœa, because it often prolongs the diarrhœa and vomiting if given in the early stage. In making the whey, the curd should not be broken up at first, but as the infant improves the curd may be more and more thoroughly broken up before straining off the whey, so that the infant may get a food containing more fat. The next step is to use peptonised milk, to which lime-water should be added to prevent any laxative effect. It is well to give alternate feeds of peptonised milk and whey at first. Sherry whey is another useful food as a stage in the return to milk.

A very important point is to give only small feeds. One sometimes finds the strength of the food has been reduced, but the child is having 4 oz. or 5 oz. feeds when ½ oz. would be much better. It is better to give a teaspoonful and have it kept down than an ounce and have it vomited. I believe it is often wise to reduce the feed even where there is only diarrhœa and no vomiting. An error often made is to continue too long the frequent small feeds. It is bad to continue giving food every hour if the child can take more every one-and-a-half-hours; the longer interval allows the stomach more time to rest.

In many cases of cholera infantum, the child cannot keep anything down at all. There is nothing, then, like a saline infusion under the skin. It will save lives which cannot be saved in any other way. After the infusion, the infant goes to sleep, and wakes up a different child. But in many cases this has to be a last resource, because parents are naturally averse to anything that savours of operation. Absorption of the fluid will be very slow, so it is better, if the child is apparently *in extremis*, to give some stimulant first, such as strychnine, or a mustard bath, or alcohol, until the infusion can take effect. But remember that strychnine in infants, even in very small doses, is apt to cause convulsions. I have seen this result from 1 ♏. of the liq. strych. B.P. If it is tolerated you can repeat a dose of half a minim after a couple of hours. As to the value of brandy, one is almost afraid, nowadays, to say anything about it. I have even been told that it is useless in any disease; my experience leads me to think that in infantile diarrhœa, as in many other serious diseases, brandy is extremely useful. But it is possible to do much harm by giving too large doses of it. I see infants who are having, as it seems to me, an altogether excessive amount of brandy, with the result that vomiting is actually excited, and kept up by this overdosing. For a child under six months, 10 to 15 ♏. is enough, and you can repeat this in a couple of hours, if necessary. 30 ♏. I regard as an outside dose for a child under a year, and I should not give that quantity unless I was hard pressed. I am satisfied that five drops of brandy put into a feed of whey or milk causes a feed to be kept down in some cases when otherwise it would be rejected. There is a carminative as well as a stimulant effect in brandy. The doctor should specify how long the brandy is to be continued; one has found brandy being given quite unnecessarily for weeks because the doctor had omitted to say when it should be stopped. Sherry whey must only be given under conditions in which you would use a stimulant. It has a remarkable carminative effect, and is sometimes kept down well when other preparations of milk are vomited.

As to drugs, my own experience is that there is not a great range of drugs which are of use in this disease. I know some people believe that opium is bad in infantile diarrhœa, but I should put it at the top of the list. There are, however, cases in which it does harm; and I think it is difficult in any given case to know whether it will do harm or not until you have tried. If you constipate an infant by giving opium, it sometimes happens that cerebral symptoms develop which make the case look like one of "spurious hydrocephalus." This is supposed to be due to the retention of the foul diarrhœal stools in the intestines and absorption taking place, so that there is auto-intoxication. Such a result, however, is very rare in my experience. How should the opium be given? The solid forms of opium are, I think, more useful than the liquid in infantile diarrhœa. Dover's powder is most useful; under three months old, ⅛ grain; six months, or under to three months, ¼ grain; and over six months, ½ grain. This may be repeated three or four times a day. If you have the child under close observation you can give more. If the stools are very offensive, it is good to combine it with ¼ grain of hyd. cum cretâ. If giving liquid opium during the first six weeks of life, I use tinct. camph. co. You may take it as a safe rule to give a quarter-minim dose of tincture of opium for every quarter year of age. But this, as I have said, can be increased if the child is under constant supervision.

Two other valuable drugs for this condition are castor oil and bismuth. I am not speaking of castor oil now as an aperient. There is much misapprehension about castor oil in the diarrhœa of infants. For clearing out the bowel, you use ½ drachm or a drachm. Its other use is as an astringent, and that is the use most commonly made in children's hospitals. We have there a mixture of 5 ♏. castor oil, 15 ♏. mucilage of acacia and dill water to 1 drachm. This mixture is almost as constipating as opium; it has no aperient effect whatever. If you give a baby six weeks old 5 ♏. of castor oil, you will occasionally get an aperient action, and 10 ♏. will usually cause such action. So for a baby six weeks old I order 4 ♏. It must not, however, be ordered every three hours, as one orders bismuth, else its effect will be aperient.

Bismuth is best given, I think, in a mixture, for the reason that the baby with bad diarrhœa is of course craving for drink, and will take the medicine in a drink; whereas if you give it a dry powder it will vomit on that account. In other conditions also you will find some children will never take powders. You need to give 5 to 10 grs. of bismuth carbonate, and you can give it every two or three hours. Some people think a great deal of disinfectants for infantile diarrhœa. They should, theoretically, do good; but my experience with them in the acute diarrhœa of infants has been most disappointing. They are useful in chronic conditions where the bowels are opened four or five times a day and the stools are offensive and the child is wasting.

There is a difference between the treatment of a case where the colon seems to be chiefly affected, and one in which the stomach is chiefly at fault. Put tersely, I should say give bismuth where there is gastro-enteritis; castor oil where there is ileo-colitis. Castor oil seems to have a very soothing effect on colon conditions; also in children with big abdomens, who are passing a great deal of mucus, and perhaps wasting like a case of tubercle. The acuter cases of ileo-colitis often do much better with castor oil than with bismuth; whereas, the child with much vomiting and loose watery stools will do better with bismuth.

Rectal irrigations are useful where there is ileo-colitis, and the child passing much slime. Some use antiseptics, others astringents, and others plain saline for the irrigations. Plain saline is, I think, as good as any. You can use 2 per cent. resorcine and tannic acid, but I do not think they do more good than plain saline; it is largely a question of washing out the intestine.

A valuable drug in cases of diarrhœa arising from affection of the colon, particularly in acute diarrhœa running on to a sub-acute condition, is silver nitrate, given in ⅛-grain doses in distilled water, perhaps sweetened with saccharine. I have tried ordinary astringents, and given an extensive trial to hæmatoxyline and catechu, and preparations of tannic acid brought out recently, and I think they are of very little use in acute cases. They are more useful in sub-acute cases.

In treating cases of acute infantile diarrhœa you must watch your patient almost from hour to hour. It is no use going on day after day with a particular drug or a particular mode of feeding if the child is not obviously improving under it. The medical man must needs exercise a close and almost constant supervision, and must be prompt to appreciate the slightest change in the infant's condition and to adapt his treatment thereto, if he would save life in these severe cases of infantile diarrhœa.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor F. Raymond, M.D., of the Faculty of Medicine of Paris; Physician to the Salpêtrière Hospital, Paris. Subject "Abortive Forms of Tabes."*

ORIGINAL PAPERS.

A CASE OF THORACIC LYMPHO-SARCOMA. (*a*)

By JOBSON HORNE, M.D., B.C., CANTAB.,

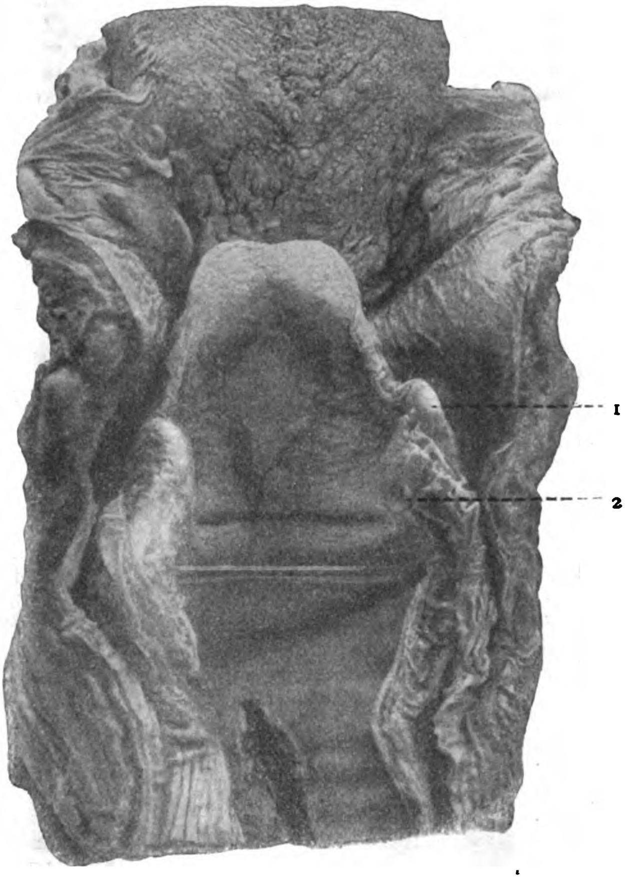
Surgeon, Metropolitan Ear, Nose and Throat Hospital, London, etc.

Clinical history.—The patient, a man, æt. 49, was quite well up to two months previous to his death, his weight being fifteen stone. He first noticed an increasing inability to eat meat, and within a month of the onset of this difficulty he was unable to take solid food, the attempt causing vomiting. He was able to take liquids by drinking fast, only about a teaspoonful returning from three quarters of a pint. Five weeks after the onset of the dysphagia—that is, three weeks previous to his death—there developed difficulty in breathing, which became worse, and was attended with "occasional spasm of the windpipe," so that he had to sit up. Latterly the attacks became more frequent, recurring twice a day, and lasting half an hour; they were worse at night, so that he was afraid to lie down in bed.

Condition on admission to hospital.—He had an anxious look. There had evidently been considerable wasting. The breathing was rapid, and associated with inspiratory and expiratory stridor, and much "wheezing," as if bronchial. He experienced a feeling as though a weight were on the chest along the sternum.

The examination of the thorax revealed no physical signs of aneurysm. Both sides of the chest moved equally; there was no area of dulness. The area of cardiac dulness was diminished; the cardiac sounds were normal. The larynx was observed to be congested, but the vocal cords moved well, and there was no sign of obstruction. A radiograph of the chest was not obtainable.

The œsophagus permitted the passing of a bougie of the largest size.



A photograph of the larynx opened from behind to show: (1) The localised œdema over the right artyænoid. The œdema has somewhat subsided in the process of preserving the specimen. (2) The puckered scar in the fold of mucous membrane passing down between the cartilages of Santorini and Wrisberg, and referred to by the author as the vulnerable spot of the larnyx as a source of systemic infection.

The patient rapidly became much worse, very cyanosed, and distressed, and on the second day after admission death occurred from asphyxia.

The post-mortem examination revealed in the posterior mediastinum a lobulated mass of new growth, the size of a large pear, apparently springing from the bifurcation of the trachea, and extending forwards into the pericardium, and downwards and backwards for the most part to the right of the middle line. The growth had bulged into the lumen of the œsophagus so considerably that the mucous membrane covering it was extremely thinned and atrophied, the œsophagus itself being obstructed by the new growth to the extent of 115 mm. in the vertical direction, the growth within its walls measuring 40 mm. across, whilst the entire width of the

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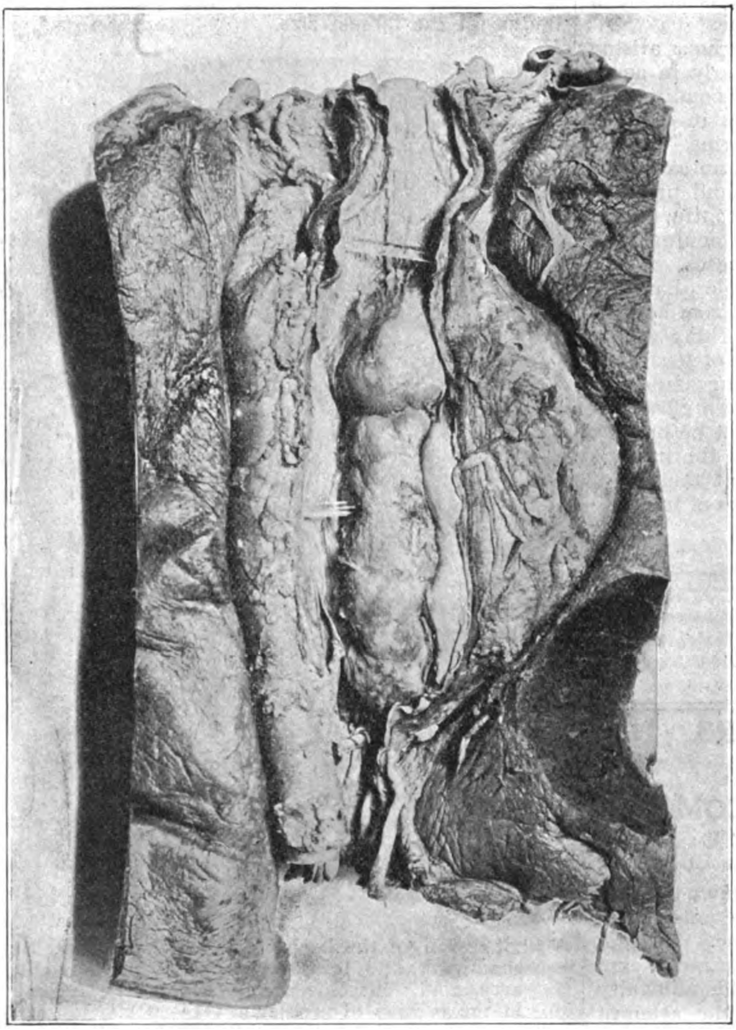
(a) Paper read before the Laryngological Society of London, April, 1907.

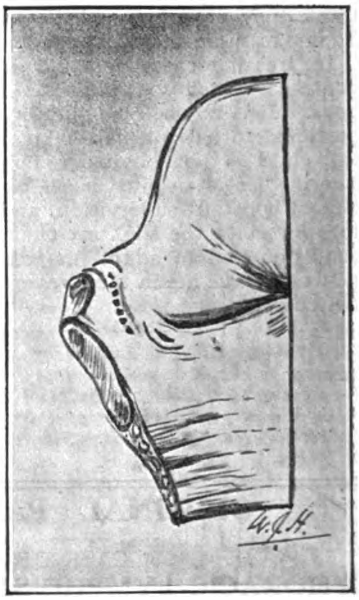
growth in the posterior mediastinum was 70 mm. There was some dilatation of the œsophagus above at the level of the bifurcation of the trachea. Both pulmonary veins were surrounded by the growth, the right bronchus, although not invaded, was considerably narrowed. There was a direct extension of the growth into the lower lobe of the right lung. There was much surgical emphysema round the root of the right lung, and also between the chest and the pleura; the lungs were somewhat collapsed, but presented no further evidence of disease.



A photograph taken from behind to show the invasion of the posterior mediastinum by the new growth. The structures entering into the photograph from left to right are:—(1) The inner portion of the left lung. (2) The descending aorta. (3) The œsophagus laid open to display that portion of the growth which bulges into, and almost obliterates, the lumen to the extent of 115 mm. The walls of the œsophagus are separated by a glass rod inserted in the upper part at a level corresponding to that of the bifurcation of the trachea. The œsophagus above this level is dilated. (4) The main portion of the growth outside the œsophagus, and to the right of the middle line. (5) The inner portion of the right lung showing the direct extension of the growth into the lower lobe.

Microscopic examination of the growth showed it to be a round-celled sarcoma.

The larynx presented, over the right arytenoid region, a circumscribed area of œdema, about the size of a raisin. On the inner aspect of the right arytenoid there was the puckered scar of an abrasion, situated in the fold of mucous membrane passing down between the cartilages of Santorini and Wrisberg, a site which I have described elsewhere as one lending itself to systemic infection, and which I have termed the vulnerable spot in the larynx (*a*). It is indicated in the accompanying diagram by a dotted line, and must be distinguished from the common site of a tuberculous ulcer, which is immediately behind and a little below the vocal process (the posterior sesamoid cartilage) of the vocal cord. There was no marked enlargement of the cervical lymphatic glands.



A diagram of the interior of the left half of a larynx to show the site referred to as the *vulnerable spot*, which is indicated by a dotted line.

The case presents some unusual features of clinical and pathological importance:

(1) The extent of the occlusion of the lumen of the œsophagus by an extrinsic new growth.

(2) The possibility of passing a bougie of the largest size, in spite of such marked œsophageal obstruction, illustrates both a clinical fallacy, which may attend the use of soft rubber instruments, and also the value of œsophagoscopy in the diagnosis of such cases; it being improbable that a rigid tube would have passed the growth.

(3) The localised œdema of the larynx might be accounted for by the conditions within the thorax. At the same time it is as well to consider the possibility of such œdema being occasioned

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(*a*) Introductory Paper to a discussion on "The Upper Respiratory Tract as a Source of Systemic Infection," British Medical Association, Annual Meeting, Swansea, 1903.

by a local infection at the site indicated. The presence of the scar in the larynx raises the interesting question whether the thoracic growth were not the result of an infection, and whether lympho-sarcoma may not eventually have to be numbered, together with the lesions met with in Hodgkin's disease, amongst the infective granulomata. The question is not necessarily negatived by the absence of enlarged cervical glands, for I have shown experimentally that after an inoculation the proximal group of glands may not be permanently affected. whilst *post-mortem* a distal group may be found markedly enlarged.

THE TREATMENT OF URINARY DISORDERS BY THE MINERAL WATER OF EVIAN.

By J. GRISEL, M.D.

Consulting Physician at Evian-les-Bains, France.

From ancient records it would seem that from the earliest times the mineral waters of Evian were used for gout, nephritic colic, gravel, and other urinary disorders. In fact the first account of a recovery due to the drinking of this water concerns a certain Baron de la Rochette, who was thus cured of gout in the fifteenth century. It is not until the end of the eighteenth and at the beginning of the nineteenth centuries that treatment of the Evian Spa was regularly applied, after the testimony of Tingry, a professor of chemistry at the University of Geneva (*a*). There were then sent to the Spa people suffering from "irritative diseases." For a long time gout and other unhealthy conditions of the urinary tract mostly brought sufferers to this spa: among them many patients affected with catarrh of the bladder, urethritis or gravel were to be seen. Even now the physicians who have been practising at Evian for a tolerably long while, can recall more than one stricture of the urethra treated there. The use of this pure water, with its accompanying mineral qualities, in such a state of dilution is, that its passage through the kidneys and urinary organs effects a regular flushing and sedative action, and proves highly beneficial to many patients of this class.

Of course the peculiar property of the water, resulting from its quick passage and rapid elimination, would make it unavailing and even injurious for people in whose urinary tract there is an obstacle to the free discharge of the urine—*e.g.*, big renal calculi, excessive hypertrophy of the prostate—especially of the median lobe—or a tight stricture of the urethra. Such patients should entirely abstain from the water, or be sent to Evian only when the obstacle is removed by means of an operation designed either to destroy the calculi or to remove the stricture, &c. (*b*) Then not only will they be able to make use of the water without inconvenience, but it will be a duty for the medical men, under whose care they are, to prescribe it, when they become aware of the benefit that their patients will derive therefrom. Under its influence the inflammatory symptoms disappear, the general nutrition is improved, and in most cases relief speedily ensues.

Is it possible to discriminate, *à priori*, between the patients who can be sent directly to this spa and those who need preparatory treatment or operation? This question finds its solution in the statement of a precise diagnosis, the elements of which we have not here to deal with. It ought, however, to be pointed out, among the latest processes of investigation, that cystoscopy, and the examination of the urine of each kidney, obtained separately with the help of Cathelin's or other "*diviseur*," would generally reveal the true state of affairs. Above all, in order to make out, as far as possible, the position and size of the calculi, it may prove useful to resort to the X-ray examination and to radiography, especially in the case of very obese persons, with the use of a compression cylinder (*a*).

Dr. O. Kraus, of Carlsbad, asserts that the biggest calculi he ever saw eliminated in an attack of nephritic colics were about the size of an almond (*b*). From another point of view the shape of the calculi is of considerable importance as to the ease or difficulty of their going out of the pelvis and down the ureter. I have before me an opuscule written by Dr. Rafin, of Lyons, relating to "renal calculi and radiography," in which some samples of stones were radiographed—first, when still in the kidneys, and then after their removal by nephrotomy; it is easy to understand that some of these concretions, in spite of their small size, would have produced severe pain when passing through the ureter, on account of the sharp points and edges that are spread all over their surface (*c*).

It will, therefore, be well to remember that the largest stones *do not*, in every instance, give rise *in situ* to the most obvious symptoms, and that, not uncommonly, gravel, and even tolerably big calculi can be passed through the ureter without acute pain. In such cases stones are often only noticed when, having reached the bladder, they cause evident disorder. How often does the renal lithiasis remain concealed, some pain or even a mere weight in the loins being noticeable, until pyelitis, or renewed hæmaturia, awake the practitioner's perspicacity!

Perhaps, by resorting more frequently to Röntgen rays, it will be possible, in many a case (*d*), to trace back to their real cause some symptoms of which the interpretation is puzzling, and therefore to infer more speedily the right mode of dealing with the disease.

But here, as everywhere in medicine, we shall probably prevent rather than cure, and attempt to stop the production and the increase of calculi by prescribing the use of the mineral water of Evian, the efficacy of which is testified by many years, not to say centuries, of experience. It is indeed the results of the latter, supported by the investigations and work of the medical profession on the spot, that Professor Landouzy summed up, when he observed (*e*) that the ingestion of the water of Evian, opportunely

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(*a*) An analysis of the mineral soapy (alkaline) waters of Evian, Geneva, 1808.

(*b*) Should they be sent here, however, suffering from acute conditions, they require the greatest care during the treatment in order to obviate, as far as possible any untoward effect.

(*a*) Dr. Arclin, from Lyons, uses, instead of a cylinder, a rubber balloon applied to the abdomen by means of a strap, at each end of which is hanging a bag filled with sand (or any other material), as much as is necessary to exert a compression sufficient to keep the wall and the kidney motionless.

(*b*) The *Lancet* No. 4366, May 4th, 1907, p. 1222.

(*c*) Dr. M. Rafin, communication à la dixième session de l'association Francaise d'urologie.—Evreux Hérisy et fils, 1906.

(*d*) As far as we can imagine from what we know of X-rays, it is possible to suppose that, in the actual state of their application, not all kinds of calculi can be revealed, those composed, partly or wholly, of lime salts will be most readily made out.

(*e*) Lecture delivered at Evian, September 12th, 1901.

prescribed, is the best plan we can conceive to modify the cellular and visceral nutritions, and to flush the urinary tract of patients affected with a catarrh of the bladder, ureters or kidneys.

SOME POINTS IN THE PROBLEM OF

ILL-HEALTH AND SCHOOL ATTENDANCE. (a)

By F. J. POYNTON, M.D., F.R.C.P.Lond.

Physician to Out-Patients at the Hospital for Sick Children, Great Ormond Street, and Assistant Physician to University College Hospital, London.

With regard to infectious diseases, I shall be content to echo a sentence in Dr. Kerr's report for 1905–1906, p. 30, to this effect :—" The time has come to press on the Board of Education the necessity for allowing the Epidemic Grant as a natural insurance against the school diffusion of disease, and as a means of allowing sufficient prolongation of the convalescent period when children have been suffering from infectious diseases."

This mention of infectious diseases leads to the question of sore throat. We know that the first symptom of such important diseases as diphtheria, scarlet fever, measles, mumps, and rheumatic fever may be a sore throat. How alive the London County Council have become to this danger in the case of diphtheria is clearly shown in their resolution to the effect that during the presence of diphtheria in any district readmission is refused to children who have been excluded on account of sore throat or diphtheria, until they have obtained a medical certificate of freedom from infection based on a bacteriological examination. But what is to be done with a child who comes to a doctor with a sore throat when there is not an outbreak of diphtheria? The bacteriological examination cannot by any means always tell us the meaning of that sore throat, and inspection is also often not sufficient. It may be a passing tonsillitis or a commencing scarlet fever. The child may be practically harmless or a virulent focus of infection, and yet the decision at first may be impossible. I am of opinion that all cases of sore throat which come to the knowledge of medical men should be excluded by a certificate from school attendance until they are well, and that school teachers should be particularly watchful for complaints of sore throat and not hesitate to bring such cases at once for inspection. I admit the danger of the abuse of this precaution by unprincipled parents, but it is a lesser of the two evils, and medical men will not, I think, be often outwitted by sore throats. Epidemics will be more easily dealt with, and more rapidly stamped out if the danger of a sore throat in childhood is clearly recognised.

A sore throat may be the first symptom of acute rheumatism or rheumatic fever, and leads me to consider next this important disease. So far as my own contribution to the discussion is concerned, it is upon this subject that I most hope to be of some assistance.

The general public are but little aware of the frequency and severity of this disease in childhood. They associate acute rheumatism with painful and swollen joints in adult life, and speaking vaguely of acidity in the blood do not realise that the disease is the result of an infection by a micro-organism and that many important organs other than the joints are frequently damaged. Should any here be in doubt as to my meaning, I would ask them to compare rheumatism to tuberculosis. Tuberculosis may attack many organs. The most familiar condition is tuberculosis of the lungs, but there may be tuberculosis of the joints, or brain, or alimentary canal. So, too, with rheumatism, there may be rheumatism of the joints, rheumatism of the heart, rheumatism of the brain, and so on.

In childhood this disease often attacks many organs, and two may be mentioned as of first importance—the heart and brain. Rheumatism is the great cause of heart disease in childhood, and it is also the great cause of chorea or St. Vitus's dance.

Dr. Newsholme some years ago pointed out that acute rheumatism was essentially an urban disease, and in London it is particularly frequent, and it is common in all large towns. This disease is strongly hereditary, and one believes this to mean that the children of rheumatic parentage have transmitted to them a delicacy of tissues which makes them especially susceptible to the rheumatic infection. The problem of rheumatism and school attendance presents several aspects. The first of these is concerned with the children of rheumatic parentage. It is an observation of general acceptance among medical men that such children are often highly nervous and subject to night terrors and headaches, and that they easily get over-excited and over-tired. They derive much good from school discipline, but when they begin to dream about their school-work at night and worry over their lessons, no children more certainly need rest and relief from mental exertion.

The next consideration is a much more urgent one, for it is concerned with the proper treatment of those children, whether of rheumatic parentage or not, who develop an attack of acute rheumatism. If the joints are affected then the pain and incapacity for movement at once renders school attendance impossible. When, on the other hand, the heart or the brain is affected—structures of incomparably greater importance—strange though it may seem, I continually meet with the fact that these children have been attending school until there is a complete breakdown. Yet no rule in medicine is probably more assured than that which lays down rest in bed as an essential treatment for acute rheumatism. How is it then that active heart and brain rheumatism are so easily overlooked? The reasons are two, the first is that their early warnings are often very indefinite, the other is that there is not a general knowledge of the fact that the conditions are rheumatic. Early heart disease is singularly free from pain, and on this account pallor, lassitude and shortness of breath are not given their due importance; vague pains are, peharps, called growing pains, and the absence of swelling of the joints tends to dispel all suspicion of rheumatism. The headaches, irritability, and irregular movements of early chorea are put down to naughtiness or carelessness, and the impossibility of fixing attention is attributed to wilful disobedience. Then those attendance medals which, from my point of view, appear to be so injurious, stimulate the child himself to hold on until compelled by illness to give up. Valuable time—invaluable time, in fact—is thus lost, for it may be asserted that though the majority of children *recover* from an attack of heart rheumatism, few escape without some *permanent damage* to the valves of the heart. Again, as I have remarked, rheumatism in childhood often affects many organs at the same time, and so it comes about that many cases of brain rheumatism or chorea, are also suffering at the same time from heart rheumatism. How can these difficulties be dealt with? No sudden or sweeping measures will succeed, I think, but there must be a gradual education of the general public to the recognition of the frequency and meaning of active rheumatism in children, and I hold it of great importance that school teachers, especially, should be acquainted with its chief dangers. They have the power of doing both children and doctors a great service by thus helping to solve what is one of the greatest problems of disease in this country—the arrest of the vast amount of organic heart disease of rheumatic origin. Much of the heart disease of adult life, let me add, dates from rheumatism in childhood.

The third difficulty in this problem of rheumatism and school attendance is the great tendency there is for rheumatism to relapse. It is a common experience in London for a child of six years of age to be attacked with rheumatism, and from that time forward to suffer repeatedly from relapses now it is brain rheumatism, now cardiac rheumatism, now joint rheumatism. The recoveries, especially from cardiac and brain rheumatism are very slow, and the cases of chorea are so numerous that hospitals cannot cope with them, and yet when they are in the convalescent stage their home-life is often unsuitable, and school attendance is quite out of the question. We need in this country some of our great philanthropists to found convalescent homes where the rheumatic children might thoroughly rest and if they only knew the sadness of children's rheumatism I am positive those homes would soon be founded.

(a) Paper read at the International Congress on School Hygiene, London, July, 1907.

The last point for consideration in rheumatism is the child with heart disease. By this I mean the child who has recovered from the acute rheumatic lesion but is left with a heart more or less damaged. These children must be educated, but they are delicate and need careful management. The disturbance of the circulation of the brain by the heart disease often makes them nervous, and cold bitter weather and long flights of stairs are most obnoxious. It is evident that no routine school attendance is permissible, and so far as possible these cases should be singled out and special arrangements made for them.

To summarise these remarks upon rheumatism and school attendance, there are four main considerations :—(1) The excitable nature of the child of rheumatic parentage ; (2) The danger of active rheumatism when untreated by rest ; (3) The stubborn and relapsing character of the disease ; (4) The delicacy of children left with chronic heart disease.

Should there be any here who think that I exaggerate the great importance of rheumatism, I need only add that if they spent one week in making the round of our large London hospitals and infirmaries they would be astounded at the answers they would receive as to the frequency and severity of this scourge. In seven years as an out-patient physician, attending twice a week at only one of the children's hospitals, I have made notes of over 500 cases in children under twelve years and have seen quite as many more.

In passing I would mention a small group of children who are born with malformed hearts and who live to grow up to adult life. These need also most careful supervision during school life and must be grouped with the victims of acquired heart disease.

Leaving heart disease I would next direct your attention to a considerable group of cases of chronic lung disease which are not tubercular. Such, for example, as asthmatics, who are often most intelligent children. Those again who have suffered from severe pneumonia and bronchitis. Many of these among the well-to-do should not be permitted to winter in England. They are delicate, and during inclement weather want supervision, but a considerable number would recover completely, I think, with more care as to their school attendance.

Kidney disease again, often a heritage of scarlet fever, is a very important condition. It is certain that if a child who has suffered from the acute disease is—from insufficient care—allowed to drift into a state of chronic kidney disease, there can be only one end—viz., persistent ill-health and early death. School attendance must then often be very imperfect until the danger of a relapse has been thoroughly warded off, and yet the ordinary observer could detect nothing amiss during this time of convalescence. Only a medical man can accurately judge the stage of convalescence. There are seasons, too, which are most dangerous to those who have had kidney disease, and I have never seen a better example of this than in last April, when there was an extraordinary increase of acute kidney disease. During such times much judgment is required as to school attendance of a child who has suffered from renal disease.

A well-organised system of medical certificates and a greater development of schools for the physically defective are two precautions of first importance in dealing with these victims of rheumatic, cardiac, pulmonary and renal disease.

I would venture to suggest (paradoxically) it may seem that in these days of specialism medical men are not sufficiently aware of these special schools, and I think something might be done by the school authorities to make them more known. We ought, I admit, to be well acquainted with them, but we are so engrossed in our own heavy duties that we need to have their existence impressed upon us. They have been a revelation to me, and I am full of admiration for the splendid work they are doing. Yet I realise that they are very expensive, and that their multiplication must mean time and money. At present, too, I think, that though a recommendation from the medical man or hospital physician should be encouraged and welcomed, the ultimate decision of admission of a child to such a school should rest with the medical officers of the school board, because, in my opinion, they alone at the present time can decide the essential point as to whether the particular case is the most suitable among the many claimants for the limited accommodation now available.

Medical certificates will need to be as brief as possible. I can assure the Education Department that they can hardly realise the labour of a modern hospital outpatient department, with its enormous numbers, its school and vaccination certificates, its letter to be signed for convalescent homes (some of which are cruelly exacting), and its teaching duties. When I say that in a morning between seventy-five and one hundred medical cases may have to be dealt with in one department at a large children's hospital, some here may understand how worrying it is to have to turn even for a moment from the actual medical work.

EPILEPTIC CHILDREN.

The next class of cases to be touched upon is a most difficult one, and this is the epileptic. It is particularly difficult because there are two separate problems. One is, that of the actual fit, the other the mental condition between whiles. The severe fits are most distressing, and are most alarming to other children. Their occurrence during a class must of necessity upset everyone. Clearly a child who is suffering from repeated severe fits should not be attending an ordinary school. Experience, however, shows that we have all grades and varieties of attacks. In a collection of about 200 cases kindly made for me by my assistants, Drs. Moon, Brincker, Sweet and Crampton, this fact is well illustrated. Among them there are a number of children who only exceptionally have attacks—once in two months, for example. Many of these are quite intelligent, and if it were not for the alarming character of an epileptic attack they would be to all intents normal children. Then there are others who have infrequent attacks, too, occurring only at night, and then for some mysterious reason suffer from storms in which forty or fifty fits may occur in a week. Others, again, steadily improve under treatment. It is then evident that even if we consider the fits alone that no single rule can be laid down for the education of these children.

The other problem concerned with epilepsy is the mental state. This also varies greatly. As a general rule, it may be said, that the occurrence of many fits, whether of the severe or mild type, will in the course of time greatly damage the mind. It is, however, equally true, that some cases degenerate much more rapidly than others, and that mental failure may sometimes follow rapidly upon the occurrence of one or two attacks. The mental degeneration associated with epilepsy is a very serious one, and the imbecility of a dangerous type ; and with regard to the mental question I should be much interested to hear from some of those who take part in this discussion the general experience of school authorities in dealing with the education of epileptic children.

In addition to the damaging effect of repeated epileptic attacks on the brain, there are the strange mental states that sometimes follow immediately upon the fit and which are transient. The most dangerous of these is mania, a condition which, in adults, has been the cause of the most horrible murders sometimes of a wholesale description. Children, though they generally sleep heavily or remain quiet after a severe fit, may also sometimes do extraordinary things and be, for a while, quite dangerous to those near them. One boy under my observation ran away from home time after time immediately after a fit.

Personal experience of epileptic children leads me to think that, from the educational point of view, we *cannot* group them into two great classes. From the standpoint of convenience this would be a simple measure, for the slight cases would attend school and the severe would go to an epileptic colony, but I feel convinced we should not have done our best, for there would be a large number left not able to attend school with regularity, and not suited for a colony. These would run a great risk of becoming uneducated, a deplorable event, when we bear in mind that even bad cases may get quite well under steady treatment and with others the fits be greatly curtailed. In dealing with this problem, I see the brightest light in an intelligent co-operation between parents, school teachers and medical men, coupled with the cautious trial of special schools for the large class of epileptics that lie between the very mild and very severe types. Deficient children form a very large class in big towns, and with many types of these I cannot attempt to deal.

I would most briefly allude to certain common conditions among the poor, which may at first sight seem somewhat trivial, but which through the ignorance and, I might even say, the degenerate carelessness of many parents are productive of great harm. These are neglected teeth, chronic ear discharges and adenoids. The teeth of poor children are horribly neglected, and the tender and offensive conditions of their mouths and gums produce dyspepsia from food bolting and anæmia from continual poisoning. Some homely instruction upon this point and some practical illustrations of the use of the tooth-brush would be as useful as any physical drill.

Chronic ear discharges are a danger to the child and an offence to its associates, and it is deplorable how callous parents are upon this point. Adenoids, by blocking the nasal passages, are the cause of much stupidity among children. It is, in fact, impossible for a child to keep his attention when the condition is severe. Few people, I think, who are fixing their attention do so with their mouths open, but these children cannot breathe if their mouths are closed. Respiration is impaired, and the blood not thoroughly cleansed, the chest becomes deformed, and middle ear disease and deafness are constant occurrences in the victims of adenoids. These cases should be properly treated and responsibilities of the parents aroused.

The last group I mention is a very large one, and it can, I think, only be dealt with by skilful and gradual organisation. Many children, naturally robust, become, particularly in the summer, pale, languid, irritable, and highly nervous. No actual disease is discovered, though some enlarged glands in the neck may raise a suspicion of early tuberculosis. Among the more well-to-do such children are promptly sent to a bracing seaside or inland resort, and lessons stopped or reduced to a minimum. Poor children cannot be got away like this and are often in a worse plight at home than they are at school. Yet we cannot escape from the fact that many severe illnesses result from the neglect of this early sign of failure of health, and that it would be a great step forward if some scheme could be gradually evolved by which these cases could be drafted to country or seaside convalescent homes in touch with country schools. An organisation of a system of convalescent homes would be required, and the whole undertaking would need the greatest caution and watchfulness in order to prevent the immediate abuse that would spring up as surely as it has in our hospitals. The present splendid effort of the Lord Mayor of London on behalf of the cripple children is an encouragement to hope for some further steps in the direction of that true education which strives to preserve the *mens sana in corpore sano.*

THE OUT-PATIENTS' ROOM.

FRENCH HOSPITAL, LONDON.

Columnar Carcinoma.

White Swelling at the Wrist.

BY A. D. KENNARD, F.R.C.S. (ED.)

AMONGST Dr. Vintra's out-patients was a man, æt. 52, who came up with a history of five weeks' slight pain in the lower part of the abdomen, and constipation, alternating with diarrhœa, and the passage of blood and mucus. He had been getting thinner for the last four or five months. No history of vomiting, though he suffered from nausea. On examination, patient had a cachetic appearance; he was not at all emaciated. The heart and lungs were normal, and liver was not enlarged. Urine, Sp. gr. 1015, contained a little albumen, but no other abnormal constituents. On rectal examination a hard ulcerating tumour could be felt about 2½ inches above the anal aperture, it admitted the passage of a finger with difficulty, and completely surrounded the bowel, and was firmly fixed to the surrounding tissues. It was, in fact, an advanced case of columnar carcinoma.

Treatment.—Patient was given a weak permanganate lotion to use as an enema every morning, and a laxative to keep the bowels open.

Remarks.—This case was in a very advanced condition, and was quite inoperable, and showed how very few symptoms accompany carcinoma of the rectum in the majority of cases. If the patient had been seen earlier it would have been quite easy to remove the tumour, as the growth was quite low down. The only question that remained was that of a colotomy, and I am in favour of delaying this operation to the very last, in fact until the symptoms of oncoming obstruction present themselves.

A woman, æt. 30, single, came up with a history of pain and swelling in the right wrist, of two months duration, caused, she thought, by lifting a pail of water. She said she had been quite healthy, except for an occasional cough. On examination, the wrist presented the familiar appearance called by the name of "white swelling." Anteriorly there is thickening along the tendon sheath, and behind a certain amount of ill-defined fluctuation could be felt. There is a loss of mobility in the wrist and there was some pain on manipulation.

On examination of the chest there was found to be diminished expansion and a certain amount of dulness at the left apex with prolonged expiration, but no râles were present.

Treatment.—The forearm was put upon a splint, and the wrist dressed wiith Scott's ointment. She was given an emulsion of cod liver oil, to take three times a day.

Koch's New Tuberculin 1–5000 of a milligramme was injected into the gluteal region, and the patient told to remain in bed for twenty-four hours.

Remarks.—This case was one of tuberculous disease of the wrist joint, with a patch of old phthisis at the left apex. These cases nearly all do well with small injections of tuberculin once a fortnight; it is advisable to take the opsonic index, but if very small doses are given, and the duration between the injections kept at about fifteen days, this was not absolutely necessary. I believe that keeping the patient in bed for twenty-four hours after the injection is of great benefit in the treatment of these cases.

THE will of Dr. Alfred Square Cooke, M.R.C.S.Eng. L.S.A.Lond., of Stroud, Gloucestershire, for thirty-seven years medical officer at the Stroud Workhouse, who died June 1st, has been proved by the widow and sole executrix, Mrs. Margaret Cooke, at £1.705 18s 7d

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

Fracture of the Lower End of the Humerus: Wiring.—Mr. **Arthur Edmunds** operated on a child, æt. 5, who had been admitted suffering from a fracture in the lower end of the humerus in the neighbourhood of the epiphysial line, the result of a fall. An X-ray demonstrated the fact that the shaft of the humerus was displaced anteriorly to the lower fragment, so that when the limb was flexed with the deformity unreduced, the bones of the forearm came into contact with the lower end of the upper fragment, preventing effectually a permanent flexion of the arm beyond a right angle. An attempt was made to manipulate the fragments into position, but this was found to be impossible, and accordingly an incision was made through the lower third of the triceps right down to the bone. The fascial attachments of the lower end of this muscle were stripped slightly to each side, so as to give access to the seat of the fracture. A periosteum detacher was then thrust forwards and downwards between the two fragments, and in this way they were lowered into position. When once in position they showed little tendency to displacement, but, in order further to steady them, a wire was passed through the outer condyle, and then carried up to a point above, and internal to it on the shaft, just clearing the olecranon and the coronoid fossæ. When the ends of the wire had been twisted up it seemed to steady the bone quite effectively, therefore no further wire was put in. All bleeding points were carefully arrested, and the muscular layer was just drawn together with a few catgut sutures. The skin wound was closed without drainage. Mr. Edmunds said that cases of fracture of the lower end of the humerus, especially in children, were amongst the most difficult fractures to deal with. They frequently involved through part of their extent to epiphysial line, but the line of fracture was pretty certain to extend into the shaft of the bone or the epiphysis. It was very difficult, he pointed out, to be perfectly certain by digital examination that accurate apposition of the fragments had been obtained, and these fractures should always be most carefully examined by stereoscopic skiagrams to see how far the attempts at manipulation had been successful. If the fragments can be manipulated into position by traction upon the flexed forearm, it was usually possible, he remarked, to maintain the reduction, the arm being put up at an acute angle, about 60°, but when, as in the present case, this cannot be done, an operation should be undertaken as soon after the injury as possible, for any imperfections of the joint surfaces lead to the greatest impairment of the joint. After wiring, Mr. Edmunds said, it was frequently found when the wound had healed that movement was not as perfect as it was at the actual moment of operation, but this difficulty was often unavoidable, as it was produced by the callus which formed about the line of fracture; this callus, however, rapidly disappears, and the movements of the joint become perfectly normal. It was rare, he asserted, that the surgeon has to operate on children under four, as in these cases reduction can nearly always be obtained. Above this age operation was very frequently necessary. Whatever method of reduction was adopted, the after-treatment, he remarked, was about the same: the arm should be put up at an acute angle; the object of this was, that at the time of the reduction it was usually possible to place the arm in any position the surgeon may desire, but a certain amount of limitation of movement always occurred, at any rate temporarily. A limb which can only move through an angle of 60°, starting at the fully extended position, was practically useless, and the patient had no inducement to use the arm, and so by the ordinary movements of every-day life increase this range. A range of movement, however, of exactly the same extent, but extending from 30° on one side of the right angle to a position of 30° on the other side of the right angle left the arm for all practical purposes perfect; the patient can use the limb freely, and by so doing would inevitably increase this range until the full flexion and extension could be obtained; for this reason the acute position should always be employed, affording, as it does, not only a more satisfactory maintenance of the fragments in position, but also an earlier utility of the limb.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Aug. 25th, 1907.

The Method of Bier.

Bier's method on passive hyperæmic stagnation tends more and more to take an important place in therapeutics. Passive hyperæmia is obtained in two ways—either by provoking the sanguine stagnation in the whole of the limb or by localising it to the affected region.

In the first case, an indiarubber band is wound round the root of the limb; in the second, an apparatus is used from which the air is exhausted by means of an aspirator or an elastic syphon. The bandages employed by Dr. Delagenière (a French authority on the subject) are made of soft indiarubber, varying in width according to the region treated—three inches for the thigh, two for the arm, and half an inch for the fingers.

The application of the band is the delicate point in the treatment and requires a certain experience to produce the desired constriction.

The arterial circulation must in no way be impeded, while the venous circulation should, on the contrary, be arrested in order to produce hyperæmia. This rule, being always kept in mind, the bandage is applied to the root of the limb, each turn covering the previous one and the caoutchouc slightly stretched so as to obtain the desired constriction by the elasticity of the band and the ends tied in a knot or, as Klapp recommends, simply welted and applied exactly, at the point of termination.

Immediately after application, the skin becomes congested, the veins turgescent, and the limb takes on a violet colour. If the patient complains of a feeling of numbness in the limb, the constriction is too tight, the band must be removed, and applied again, for in no case should it cause suffering.

When the band is well tolerated, it can be left on an hour, and the séance repeated several times a day. In case of acute inflammation, M. Delagenière leaves it on twenty or twenty-two hours a day; in such cases the constriction is not so tight, but the patient must be watched for fear of accidents.

When the séance is ended, the band is removed, when the violet colour of the skin disappears and gives place to a bright red coloration. The numbness caused by the constriction also disappears, and the patient experiences a *bien être* which lasts to the next application.

In certain regions (axillæ, neck, trunk, abdomen, inguinal regions) the band cannot be employed. It is in such cases that recourse is had to the apparatus already alluded to, of which the simplest kind is the ordinary instrument for dry cupping, composed of a glass dome surmounted with an elastic ball by which the air is expelled; others are more complicated and require aspirators. With these apparatus, the séance should not last more than five minutes at a time, but should be frequently repeated.

The applications of Bier's method are very numerous. They render great service in cases of boils and anthrax, where the dry cup can arrest the non-suppurating boils in four or five days, while where suppuration has set in, a small incision is made with the bistoury and the dry cup applied, it withdraws the pus and produces a rapid cure.

Inflammatory abscesses and frequently cold abscesses after incision, whitlow, phlegmon, should be treated by long séances, but the band must be attended to as certain patients present a special susceptibility of the skin, recognised by phlyctenæ indicating that the constriction should cease.

Bier's method gives also excellent results in the treatment of abscess of the breast, acute or chronic. The same may be said of suppurating or non-suppurating ganglions. Each séance should last one hour.

In cases of crushed limbs, the band applied for one hour, twice a day, is very beneficial and frequently a whole limb or a part of it is preserved, which otherwise would have to be sacrificed.

In fractures, the consolidation is more rapid if the band is applied to the root of the limb for one hour every morning.

Osteitis osteo-myelitis, tuberculous osteitis, spina ventosa are very favourably influenced by this treatment.

The hyperæmic stagnation favours the absorption of articular effusions. In chronic hydrarthrosis, and in hæmorrhagic arthritis, it gives splendid results.

In acute tuberculous arthritis, the application of the band has a remarkable effect by diminishing rapidly the redness, the pain and the inflammatory phenomena.

Orchitis, treated by an indiarubber tube rolled around the scrotum, yields readily.

Such are the principal cases in which the Bier method is indicated. The mechanism of its action seems as yet somewhat mysterious, and the different theories proposed are not fully satisfactory. But there is one point on which it is necessary to insist—the application of the method requires training and a good deal of patience in order to arrive at good results.

INTERTRIGO IN THE ADULT.

The inguinal region is the favourite seat of intertrigo in the adult, and the cause is generally to be found in obesity.

Eau de Cologne, 6 ozs.
Tincture of iodine, 2 ozs.

Or,

Liquid saponified tar, 4 dr.
Eau de Cologne, 6 ozs.

Or,

Ichthyol, 2 dr.
Water, 4 ozs.

Applied as lotions.

Where the lesions are more aggravated, a solution of nitrate of silver (1—15) or permanganate of potash (1—2,000) might be employed, followed by an application of—

Oxide of zinc, 4 ozs.
Carbonate of bismuth, ½ dr.

Lanoline Vaseline	aa 4 dr.

In women, the intestrigo is complicated with intolerable itching of the vulva, with œdema. The following ointment renders service:—

Codol, Oxide of zinc	aa 1 dr..
Ichthyol, Resorcine	a a xv gr.
Vaseline Lanoline	a a 4 dr.

THE report of the medical officer for Leicester shows that the week produced only a single death from diarrhœa. In 1902 the corresponding week yielded but two.

GERMANY.

Berlin, Aug. 25th, 1907.

THE TREATMENT OF BACKWARD DISPLACEMENTS OF THE UTERUS.

AT the Hufeland Society Hr. Strassmann brought forward the subject: "When and in What Way are Backward Displacements of the Uterus to be Treated?" There were in Berlin, he said, 80,000 women with retroversio uteri. This displacement did not occur amongst the lower animals. The uterus in them was longer and reached to the kidney region; moreover the manner of walking on all-fours prevented its falling back. Without a doubt the upright position was the principal cause of the abnormality; there was also the width of the pelvis necessary for the passage of the head of the child. The human uterus developed in a certain position. The flexed anteversion was maintained bythe abdominal walls and increased by abdominal pressure. No flexion of the organ backwards occurred even after severe injuries, as the uterus was, considering its importance, the least protected organ in the body.

It might have a wrong position to begin with; retroversion was either congenital or acquired. The latter was the most frequent. The sixth part of backward displacements was congenital (in virgins and nulliparæ). A mechanical action was not excluded: 1. by the conventional over-distention of the bladder; this caused a softening and backward pressure of the part; 2. by the habitual overloading of the rectum. Both factors were in action in childbed. The ligaments of the uterus acted as a kind of stay. If the uterus once became displaced backwards further changes took place. The anterior vaginal wall became free and the bladder became more easily distended. Cystocele occurred and the anterior vaginal wall became depressed. The rectum also became distended, a rectocele formed and prolapse easily took place. The utero-sacral ligaments played but a small part. The cervix as a firm tube had also an importance as regarded position, as had also cicatricial changes of the portio vaginalis.

Consequences of the displacement. The broad ligaments embraced the uterus and these were responsible for many troubles. Twisting of the vessels took place, venous stasis followed, with the formation of varices. The posterior lip became thick and pale and not infrequently there was erosion; the anterior vaginal wall became thin. The uterus as a whole thickened and disturbances of menstruation showed themselves; it became more profuse with excretion of mucus in consequence of endometritis. Pains occurred when the mucus was expelled in virgins and nulliparæ. The displacement of the ovaries was also of importance. The follicular hæmatomata became larger from venous stagnation. An anticipating menstruation might take place, occasionally the formation of hæmatomata of the ovary might take place and, by transudation, small cysted degeneration of it. Fertility was often disturbed It might not cease as the flexed organ might become pregnant. In many cases, however, bleeding took place in the membranes, followed by abortion. The impeded gravidity was a result of the change of direction of the portio vaginalis.

Patients complained of a feeling of continuous pressure downwards. The vessels of the rectum were full and compressed, and the patients suffered from hæmorrhoids and reflex gastric troubles, although the tongue was clean; hysterical symptoms; in severe cases there may even be amaurosis and paralysis.

A large part of the troubles might undergo compensation by the body itself. The uterus could only become erect during pregnancy. Adhesions were formed by small extravasations of blood from the ovaries, etc. In secondary displacements no operative measures should be undertaken during the first year. In nine months most of the excitors of inflammation were dead. Later than that sterile pus was found. Here tamponnade and sitz baths were useful.

Treatment.—Not every case of retroflexion required operation. Where the symptoms were slight and the patient beyond the climacteric, operation might be dispensed with. There were a number of cases in which treatment by pessaries was sufficient (16 20%) these were cases without complications of laceration of the cervix or perineum.

Operation was reserved for those cases in which the uterus could not be brought into position otherwise. The speaker then discussed the various operations and expressed his preference for vaginal fixation.

Prophylaxis.—Nothing need be said about the congenital form. Every lying-in woman should be examined about the end of the third or beginning of the fourth week, if displaced the uterus should be put right and a pessary inserted. Too early getting up as some patients desired favoured the displacement.

AUSTRIA.

Vienna, Aug. 25th, 1907.

COLLUM ANATOMICUM HUMERI.

EISELBERG presented a patient at the Gesellschaft suffering from a fracture of the anatomical neck of the humerus in the left arm from a fall. Immediately after a very large hæmatoma formed on the inner side of the arm below the fracture. The pulse in the radial and cubital regions was imperceptible. He thought this a very good example for demonstrating the danger of gangrene from bandaging in fractures. He admonished careful vigilance of the pulse in the fractured extremity when applying a bandage for fracture.

PHOSPHORUS NECROSIS.

Teleky followed with a statistical account of the past and present incidence of this disease. In the Vienna hospitals at the present time this disease was very rare owing to the decadence of the match-making industry. During the last decennium the factory inspector had only 75 cases to report, while in the preceding period for the same time 400 were reported. Whatever the philosophy of the nature of the poisoning, one thing is agreed upon, that some ill-defined change takes place in the osseous system that leads to destruction.

The nature of the disease seems to be a contradiction of our therapeutic dogmas, that bones require phosphorus for their building and repair, for in the match works it is the bane of the industry whose operatives suffer from a friable state of the long bones, particularly of the arms, that spontaneous fracture often occurs amongst them.

This altered state of the bone leads to a low resisting power in purulent attacks that occur in the jaws where the bones are more exposed to the fumes. It seems that the purulent cell is first stimulated in the periosteum that succeeds the altered state of the bone by some metamorphoses in the nutrition which, when produced, allows the purulent cell to commence its destruction of the periosteum, and finally of the bone which depends on it for its support. Having once obtained a lodgment, its ravages extend to more remote portions of the body, more particularly to the brain, from which 20 per cent. of these patients die. The pus cell seems to be carried to the brain or some of its coverings, where a new centre of inflammation is produced, generally resulting in death.

The membrane of the eye is another portion of the body that the purulent cell attacks with violence, doing irreparable damage.

The therapy of this disease has not been a success, as we are as yet undecided on the primary cause. Conservative treatment is therefore the safest course in improving the hygienic condition of the operation.

Different countries have adopted different methods of manufacture for the same reason—one preferring yellow phosphorus, others white.

EXTIRPATION OF CARCINOMATOUS UTERUS.

This is an operation that one surgeon praises in youth, but as age advances can see very little benefit derived.

Veit records twenty of these operations without a death. Eighteen of these had uterus, ovaries, tubes and glands removed, the other two had the vagina removed as well after Freund's advice, but he thinks Wertheim's technique better. With the use of spinal anæsthesia he has no scruples about heart failure, which is always a grave concern when chloroform is used. The results are much better when no chloroform is used. Veit tells us that too much is made of the surroundings containing the carcinomatous germs, but there is no such virulence to be dreaded if the parts be kept clean of the cancerous surface, and the abdomen kept dry afterwards.

PANCREATIC REACTION IN URINE.

Eichler has been experimenting with Cammidge's test for the pancreatic reaction in the urine as a diagnostic test for the disease. Cammidge found that when Phenyl hydrazin was added to the urine of a patient suffering from pancreatic disease, a white or bright yellow precipitate was formed. This was supposed to be the result of some fatty necrosis. Eichler fermented the pancreatic secretion, and split up the fluid into a fatty acid and glycerine. The glycerine was separated from the urine by boiling with HCl., and converting it into glycerose, which afterwards admitted of the Phenyl hydrazin test. Three dogs were next affected with the pancreatic disease, the urine tested with a positive result, while the control of healthy dogs' urine was negative.

CONTINENTAL HEALTH RESORTS

[FROM OUR SPECIAL CORRESPONDENT.]

CHATEL-GUYON.

CHATEL-GUYON is justly entitled to a high position amongst Continental Health Stations, because of its readiness of access from our shores, its pleasant surroundings (interesting alike to artist, scientist, and antiquarian), its good Bath and hotel accommodation, its talented medical staff, granitic dry soil, pure and light atmosphere, and, above all, the excellence of its mineral springs. Particularly, its waters are most important for treatment of intestinal, stomachic, and liver diseases.

Situated in the Department of Puy-de-Dome (part of the historic Province of Auvergne), its location is the very centre of France.

Southerly and Easterly it overlooks the vast plain of Limagne; Northerly and Westerly, it is shielded by the Auvergne mountain-chain. September is its desirable month for British visitors; "*the Season*" prolonging itself pleasantly through October.

As at the neighbouring Spas of Bourboule, Mont. Dore, and Royat, remains here attest the knowledge and use of Chatel-Guyon mineral-waters by the Romans. The present Bath-Establishments (the "*Grands Thermes*" and "*l'etablissement Henry*") contain:—

Baths with running mineral-water at the natural temperature of 28° and 34° Centigrade;

Baths with standing mineral-water at any temperature required;

Baths with more or less concentrated mineral-water at any prescribed strength and heat;

Baths of medicated waters, vapour, hot-air, douches, massages, local lavages, &c.

The electro-therapic installation is up-to-date and complete for electro-intestinal lavages, hydro-electric baths, carbonic-acid baths, vibratory massages, and continuous-current baths.

The Twenty-seven Mineral Springs emerge at the junction of the primary rock (extraordinarily hard red porphyric quartz) with the tertiary Limagne soil. They yield over five million litres every twenty-four hours; the whole enormous flow being absolutely protected from the slightest possibility of contamination or admixture in the passage from the primitive rock to the concrete-lined cast-iron reservoirs.

The analyses of the different Springs are almost identical, and are thus given by three distinguished chemists:—

Chlorides: Magnesium, 1.563; sodium, 1.633.

Bicarbonates: Lime, 2.176; soda, 0.955; iron, 0.685; lithia, 0.0194; potash, 0.2538.

Free Carbonic Acid, 1.112.
Sulphate of Lime, 0.5.
Only traces of Silica, Arsenic, Alumnia, &c.
Total per litre of water, 8.3986 *gr.*

At Chatel-Guyon these waters are employed in medicinal treatment both internally and externally. For internal purposes, five burettes are in the two Parks. Three, from the springs *Yvonne*, *Deval*, and *Germaine*, showing 33° to 36° Centigrade; and two, from Springs *Gubler IV.* and *Marguerite*, 26°. They are usually drank three times daily (one hour at least before each principal meal), and at intervals of several minutes. Their action, *immediate*, is tonic and stimulating to the nervous system; *secondary*, stimulative to the digestive functions; and later they affect the intestines. Digestion becomes more active and regular; urine passes more rapidly, plentifully, and thoroughly; gravel frequently occurs; uric acid (in gouty cases) first increases, then gradually disappears; phosphoric acid diminishes; urea and chlorides increase; albuminuria, if due to liver or digestive troubles, rapidly improves.

In the running-water baths, the temperature at *les grands Thermes* is 34°, and at the Henry Baths about 28° Centigrade; these temperatures being the natural ones.

The special feature of the external treatment at Chatel-Guyon is a Bath Carbogaseous, with freely-flowing Mineral-Water at its natural temperature, so conserving without any modification its richness in gas and in salts. Owing to the great copiousness of the Springs, 1,000 litres is frequently used in each daily bath; thus representing a dose of about 8 kilos of mineral-salts and 2,000 litres of carbonic-acid. Dr. Angelby therefore justly claims Chatel-Guyon unrivalled, in this respect, on the Continent.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE NEW HOSPITAL AT AYR ASYLUM.

THERE are several special features of the hospital which has recently been added to Ayr Asylum, to which attention may be usefully drawn. It is a substantial one-storeyed building, after the cottage hospital type, specially designed for the accommodation of those insane patients who are more appropriately treated in a building of hospital character, and the design gives effect to certain principles which, in the opinion of the medical superintendent, Dr. Easterbrook, should underlie the construction of a mental, as distinguished from an ordinary hospital, specially the principle of the treatment of active insanity by rest in bed in the open air, isolation, and other special measures for the alleviation of mental and nervous disorders. The design, it may be added, facilitates the work of the staff, which may in consequence be relatively smaller than usual; and so, while an efficient instrument for its purpose, is distinctly economical to administrate. Another important point is that owing mainly to the elimination from the design of everything which was considered superfluous, and notwithstanding the fact that the cottage-hospital type of structure is relatively expensive to build, the hospital at Ayr Asylum has cost, for total construction and fittings, £100 per bed, which is considerably less than the cost per bed of asylum hospitals hitherto. Efficiency for its purpose, low cost of original construction, and permanent saving in future expenditure on upkeep and administration, are cogent reasons at this time, when the public press is constantly harping on the cost of modern asylums and the ever-increasing burden of the lunacy of the country, for this descriptive note of the latest addition to our institutions for the treatment of the insane. Although the cost of this new hospital per bed is so much less than has before been considered reasonable, no detail appears to have been overlooked, the explanation being that while securing the means of efficient treatment, the medical superintendent was permitted to eliminate from the design everything that could be considered superfluous.

A COLOSSAL ENTERPRISE.—Notwithstanding the strenuous efforts of certain legislators and well-disposed temperance reformers in the direction of what is euphemistically styled, "the drink problem," more elaborate machinery and distilleries of greater capacity are still found to be needed, at least in the whisky trade. Last week there were opened in Glasgow the largest bonded stores of their kind in the world, which have been erected in Washington Street, by Messrs. James Buchanan and Co., the well-known whiskey distillers and blenders. Some idea of the extent of the buildings will be conveyed when it is mentioned that the site is as extensive as a large cricket field, and the warehousing capacity is 20,000 butts, representing a Government Revenue duty of £1,500,000. There are two blending vats of 20,000 gallons each, and nine others from 10,000 gallons downwards. In the blending department the contents of the vats reach the total of 70,000 gallons; whilst the contents of the vats for the bottling department are 30,000 gallons. In describing this colossal undertaking, the *Daily Telegraph* remarks that one week's work is equivalent to a pile of cases four deep, reaching to the height of Ben Nevis; and eight days would yield a stock of single cases as high as Mount Everest. A week's bottles laid end to end would be over fifty-three miles long. The employés engaged in the enterprise number over 650, and the Inland Revenue department is represented by two supervisors, each with a separate office, assisted by a staff of twenty officers.

BELFAST.

THE NOTIFICATION OF DEATHS FROM INFECTIOUS DISEASES.—During the sittings of the Health Commission, the question of the notification of deaths from infectious diseases, including tuberculosis, was under discussion several times, and as a result the Corporation applied to the Local Government Board to know the limits of their powers to expend money in obtaining such notification. The Board informed the Corporation that they had no statutory power to authorize such payments, and referred them to the Registrar-General as the official who could and should furnish the returns regarding such cases. The Public Health Committee applied to him, and hoped for a favourable reply, but have just had an answer regretting that he cannot give the returns to Belfast which in the case of Dublin he supplies to the local authorities each week. It appears that in the case of Belfast the material with which the Registrar-General deals is quite different from that which he receives from Dublin. In the latter city he receives full particulars, which are tabulated in his office, but from Belfast he receives only numerical returns, the tabulation being done by the local registrars. He could not, therefore, give full returns unless he had the full information to deal with, and even if the information were sent to him, with his present staff, he could not deal with it. He concludes with a sentence of interest to Dublin: "I beg to add that, as it appears from a letter from the Town Clerk of Dublin, printed on page 239 of the evidence given before the Belfast Health Commission, that of the lists of persons dying of infectious diseases furnished weekly to the Dublin Corporation from this department, the list of persons who have died from pulmonary tuberculosis 'is the only one which is really of advantage to the Corporation,' the question must now be considered whether the department should be put to the trouble and expense of furnishing information which is declared not to be of practical value."

IN Committee of the House of Commons on the Expiring Laws Continuance Bill, Mr. Lupton moved the omission of the Vaccination Act of 1898, because since the Act came into force cancer cases had increased by over 5,000 a year, which was due to the substitution of calf lymph for humanised lymph!

LETTERS TO THE EDITOR.

"THE USE OF COCAINE IN THE MORPHIA HABIT: A WARNING."

To the Editor of The Medical Press and Circular.

Sir,—During the past six months, I have had several morphia *habitués* under my care, who, on the advice of medical men, have taken cocaine with a view to curing themselves of the morphia habit. It cannot be too widely recognised that it is not only useless but in the highest degree dangerous to prescribe cocaine in these cases; it is true that cocaine does to a certain extent neutralize the effect of morphia, but this, in point of fact, is a disadvantage rather than a gain, as it merely tempts the patient to take larger doses of morphia and then balance the excess with a heavy dose of cocaine.

But the principal danger lies in the fact that such treatment inevitably produces the cocaine habit, by the side of which the morphia habit is comparatively insignificant; uncomplicated chronic morphinism is usually curable, but, when patients begin to take cocaine also, the difficulties of the situation are increased a hundredfold; not only is their immediate condition rendered worse by the advent of delusions and hallucinations, but their chance of ultimate cure is very much lessened, and relapses are much more common than in cases of simple morphinism.

The sudden withdrawal of cocaine leads to no actual distress or reflex disturbances such as occur in the case of morphia, and, when once patients know this, they are very apt to return to the cocaine, reassuring themselves meanwhile that they can break it off at any time without acute suffering.

In a fairly large experience of morphia cases, I have never seen a single cure expedited by the use of cocaine, and its dangers are so great as to make its recommendation quite unjustifiable.

I am, Sir, yours faithfully,
J. Henry Chaldecott.

Harley Street, W., August, 1907.

THE MEDICAL ASPECT OF DENTAL CARIES IN CHILDHOOD.

To the Editor of The Medical Press and Circular.

Sir,—It is very satisfactory to find that the medical profession at length has been brought to recognise the relation of dental disease to general pathology, and to note also that leading physicians, like Dr. G. F. Still, of King's College (whose paper appears in The Medical Press and Circular of August 14th) take occasion to bring forward and emphasise all the facts of practical importance bearing upon the question. One cannot help, further, feeling satisfaction at the knowledge that even in smaller country towns there is now usually to be found a properly qualified dental surgeon fully competent to co-operate with medical men in cases where special skill is needed. It is perhaps enough that the physician should recognise and act upon the fact that the teeth need taking into consideration as possibly the sole or contributory causes of systemic disease. It perhaps matters little if he has not a complete and correct acquaintance with the etiology and pathology of dental diseases. It would, however, save some mistakes, such as, I think, Dr. Still falls into, if some fundamental facts of dental physiology were fully understood and kept in view. One such fact is that enamel and dentine, when fully calcified, or when the process of their development has ended, are incapable of physiological activity. They are not the seat of malnutrition or of processes of atrophy or wasting, and any changes these tissues undergo after completion can be due to external agents alone. The exteriors of the crowns of all the temporary teeth are fully formed at birth; and these teeth can be influenced therefore only through the mother. By this time—at birth—the first permanent molars, incisors, and canines are so far advanced in development that it is more than doubtful whether treatment could have any effect upon their enamel. Rickets and all infantile diseases of malnutrition no doubt are associated with ill-made dental tissues, and, if the mothers could be taught and made able to maintain their own health during pregnancy, could be taught and made able to suckle their babies during the proper period, and if they could be taught and made able to feed them properly during childhood, much degeneration of developing dental tissue might be stopped, and much subsequent dental disease prevented. Imperfect formation and calcification of the tissues—especially enamel—constitute the chief predisposing cause of caries. Perfect enamel will endure almost any amount of neglect or ill-usage, but no amount of care will save teeth the tissues of which are easily damaged mechanically and easily dissolved by the weak acids, the product of fermenting particles of food, against the action of which it is impossible fully to guard them. In rickets and other such diseases there exist inherently defective tissues, whilst the constantly foul and vitiated secretions of the mouth which are always observable provide the agents by which the enamel and dentine are gradually penetrated at their weakest spots and more or less rapidly broken down.

I am, Sir, yours truly,
M.R.C.S., L.D.S.

London, W., August 25th, 1907.

MILK AND TUBERCULOSIS.

To the Editor of The Medical Press and Circular.

Sir,—Permit me to thank Dr. Granville Bantock for his reply to my query. That gentleman, after reading Dr. Armstrong's able summary of current knowledge on the above subject (The Medical Press and Circular, August 7th) nevertheless retains his attitude. It is, as I before remarked, Bantock *contra mundum*. He apparently denies all the demonstrated and easily-demonstrable facts leading up to the conclusion of the argument on the mere ground that it is impossible to trace out the origin of tuberculous infection, and to place one's finger on the exact source of contagion in particular instances. The possible sources of infection in the case of the cow asked for by Dr. Bantock, are named by Dr. Armstrong, and he states the fact which I also mentioned, that the long period of incubation in the human subject prevents, at present, determination of the source of the poison and the time of its reception. Dr. Bantock says I "accept statements not supported by any evidence." I reject his statements on precisely that ground. On the other hand, I accept the statements of bacteriological science with regard to tuberculosis, because I am satisfied that if I investigated the matter for myself I should arrive at the conclusions accepted by Dr. Armstrong and the vast majority of practical sanitarians. Dr. Armstrong accepts them, no doubt, like I, because he knows that the chain of facts has been proved by scores of independent workers in scores of pathological laboratories throughout the civilised world. Dr. Bantock has detached passages from Dr. Armstrong's paper which give a distorted view of the argument and conclusions. It is, of course, a demonstrated fact that malnutrition, and insanitary surroundings predispose to tuberculosis, as they do to many other diseases. These predisposing causes are being diminished, but it will be many years before they are eliminated. In the meantime, everyone—except, I suppose, Dr. Bantock—will take part in the endeavour to discover and destroy the sources of tubercular infection in every situation in which they are known to appear or suspected to exist.

I am, Sir, yours truly,
A Family Doctor.

August 22nd, 1907.

IS CANCER CURABLE?

To the Editor of the Medical Press and Circular.

Sir,—Having read the interesting report of the discussion on Cancer, I am tempted to ask the following questions: (1) Is cancer *curable* by operation? (2) What time must elapse from date of operation till patient is certified as *cured?* (3) Can the diagnosis of uterine cancer be *made to a certainty* by any means at our disposal, including the microscope ? (4) Cancer being a constitutional disease (somewhat like tubercle) how can the removal of its various manifestations arrest the disease for good, or prevent its showing itself again by metastasis ?—I am, Sir, yours truly,

Alexander Duke.

London, W., August 24th, 1907.

OBITUARY.

MAJOR HARRY FREDERICK WHITCHURCH, V.C., M.R.C.S., L.R.C.P.

We regret to announce the death, on August 17th, at Dharmsala, Punjab, of Major H. F. Whitchurch, V.C., of the Indian Medical Service. Born in 1866 in the Isle of Wight, he entered the Indian Army at the age of twenty-two, and took part in the Lushai Expedition, including the relief of Changsil and Aigal, for which he had the medal with clasp, and in the operations in Chitral in 1895, including the defence of the fort during its investment in March and April. For these operations he obtained mention in despatches, and was awarded the medal with clasp and the Victorian Cross for an act of conspicuous bravery in rescuing Captain Baird, who was wounded during a sortie from Chitral Fort. Major Whitchurch was also engaged in the campaign on the North-West Frontier of India in 1897-8, taking part in the defence of Malakand, the relief of Chakdara, the action of Landakai, and the operations in Bajaur and in the Mamund country, being again mentioned in despatches and receiving two clasps He also participated in the operations in China in 1900, when he was a third time mentioned, and was awarded the medal with clasp.

LABORATORY REPORTS.

ALLSOPP'S LAGER.

The reading of a paper at the recent meeting of the British Medical Association at Exeter on the subject of "alcohol" produced a somewhat heated discussion on the relative values and uses of this agent in the practice of medicine, light beers, such as are in common use in Germany, receiving commendation by several speakers.

In 1899, when Messrs. Allsopp first commenced the manufacture of lager beer in this country, we published an analysis and report on the same by Sir Charles Cameron, which plainly showed the excellence and purity of this lager. We have recently submitted samples of the beer to a fresh analysis, and have obtained results practically identical with those of Sir Charles. We find the beer to contain—

4.38 per cent. of extractives,
0.26 per cent. of mineral matter, and
4.06 per cent. of alcohol (by weight).

It is absolutely free from arsenic, while the flavour and aëration leave nothing to be desired. To produce beer of this purity, the materials used must necessarily be of the highest quality, which, together with the method and conditions of manufacture, allows the production of a beverage, which, in our opinion, is much to be preferred to the ordinary lager of German manufacture. We would commend this beer to the dyspeptic and debilitated, as a routine beverage on account of its low content of alcohol, and its tonic and stimulating properties. This lager can with confidence be recommended to patients where it is undesirable to prescribe other forms of alcohol, and its substitution for ordinary beer and whisky would, in the great majority of cases, be productive of nothing but good. The brewers claim many virtues for their beer, and so far as our experience goes, these claims are well justified.

LEMONADE.

The present summer weather has not so far been of such character as to necessitate frequent resort by "the thirsty soul" to the many tempting forms of lemonade put forward by manufacturers of this favourite yet harmless beverage. We have just had sent us for laboratory examination a granulated powder made by Messrs. Foster, Clark and Co., of Maidstone, called "Eiffel Tower Lemonade," which we have tested both chemically and practically, and find it to be what the manufacturers claim for it—a concentrated essence of the juice of lemons solidified and granulated. A strong recommendation to this form of manufacture, especially in large establishments such as hospitals, convalescent institutions, and the like, is its extreme simplicity. One has but to empty the powder into water with the necessary quantity of sugar, and the lemonade is ready to drink.

REVIEWS OF BOOKS.

COOPER'S RONTGEN RAYS. (*a*)

This is a well-written little book, intended to inform the general practitioner of the help he may get in practice from the Röntgen rays. The section upon renal calculus is especially clever, and gives the exact information that is wanted by those who are not experts in the art of radiography. The most popular part of the book will probably be that which deals with treatment. We are glad to see that Mr. Cooper recommends the practitioner who has only an occasional case of ringworm to treat to use the fractional method as against that of the single maximum dose, which is dangerous in any but skilled hands. The use of the rays as a depilatory in ordinary hypertrachosis is very properly condemned. The brilliant results often obtainable in eczema of the anus combined with pruritus should be borne in mind by every practitioner of medicine. The treatment of rodent ulcer by the X-ray tube is much lauded by some authorities. The author, however, testifies that the scar is almost certain to break down again sooner or later. This fact is not always estimated at the proper value in considering the therapeutics of the Röntgen ray in relation to lupus. In our own opinion, for the majority of cases early surgical measures are incomparably the best means of attack. This excellent little volume may be commended to all who need a condensed and trustworthy guide book to this branch of medical science.

THE ANALYSIS OF WATER. (*b*).

The scheme of analysis prescribed in this book is said to offer two advantages—the analysis is quickly done without involving the use of cumbersome apparatus and by persons having only a small knowledge of water.

Although there are parts of the world where expert analysts are non-existent, and where the collection of apparatus and chemicals supplied by Messrs. Burroughs Wellcome and Co. would be useful, it is probable that in very many cases where a proper chemical analysis could be performed, Dr. Thresh's less satisfactory scheme is followed, and Dr. Thresh would be the first to deplore this. Further, although a man may in a short time master the technique of water analysis, it requires years of continuous study before he can place a correct interpretation on the results of his analysis. Hence the scheme propounded in this book may, in the hands of a novice, be a source of great danger. Could the analysis of water be simplified, medical officers and analysts would be glad to accept the innovation, but as it is they are justified in declining to place lives in jeopardy by adopting the well meant but dangerous idea of Dr. Thresh.

(*a*) "The Röntgen Rays in General Practice." By R. Higham Cooper, L.S.A., in charge of the Radiographic Department at University College Hospital. London: Bailliere, Tindall and Cox. 1907. 2s. 6d. net.

(*b*) "Une Methode Simple pour l'Analyse de l'Eau." By John C. Thresh, M.D.(Vic.), D.Sc., D.P.H. Translated from the Fifth English Edition by Drs. Magnier and Thiry. Pp. 62. London J. and A. Churchill. 1907. To be obtained from Messrs. Burroughs Wellcome and Co., London.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Hyoscine Anæsthesia in Obstetrics.—Butler (*Amer. Journ. Obstet.*, August, 1907). Despite the discouraging reports of early observers, the new method of securing anæsthesia in obstetrics is being widely tested and rapidly coming into favour. The most important report on the subject is that of Gauss, of Freiberg, who gives his experience of 1,000 cases anæsthetised with hyoscine. He insists on the use of pure alkaloids, and he states scopalamine is apt to be contaminated with bodies which seriously modify its action. This seems not to be the case with hyoscine derived from hyoscyamus. The object sought is the production of a peculiar state of half narcosis, known as "twilight-sleep." From this the patient may be awakened at any moment if desired, but does not retain recollection afterwards. The first injection is given when the pains become really severe, and consists of three to four decimilligrammes of hyoscine with one centigramme of morphine. Half an hour later the patient is shown some test object, and in thirty minutes more is asked if she remembers what was shown her. On this Gauss lays stress, since the capacity to remember regulates the dosage, rather than the cries of the patient, which are less significant. When the patient remembers the test object, a second injection is given of hyoscine alone, unless the pain is excessive, and only then is the morphine repeated. Usually four injections suffice, at intervals of not less than one hour, generally two to four hours. The ears are stopped to exclude noises. The secrets of success lie in the choice of good, fresh preparations beginning with small doses, and careful testing of the memory power as a means of regulating the doses. The causes of failure are—forcing the effects by large doses too often repeated, beginning the process too early in the labour, or leaving it until there is not sufficient time for the effect to develop, or, finally, regulation of the dosage by the patients cries. In regard to the effects on the mother, Gauss found the women complain of thirst, as hyoscine lessens mucous secretions; hallucinations and delusions of transitory character were occasionally noted. No effect on the secretion of milk could be detected, and Gauss declares that hyoscine does the child *in utero* no injury whatever. F.

Care of Nipples and Breasts during Pregnancy and Lactation.—Lagusua (*Amer. Journ. Obstet.*, August, 1907. The author of this paper says that during pregnancy, if the nipples are well formed and not painful, no treatment except absolute cleanliness is necessary. If the nipples are small, it is best to use massage in the shape of traction for fifteen minutes daily during the last two months, using boracic acid vaseline as a lubricant. During lactation, the breasts and everything that touch them should be kept as aseptic as possible, and enveloped in sterilised gauze. If there are cracks in the nipples the application recommended is nitrate of silver, 1-10, applied with cotton on a stick. When the patient does not nurse her infant, the breasts and axillæ should be enveloped in cotton pads and a firm bandage applied, which remains on till the milk disappears from the breast. If they become painful and full, Rochelle salts should be given. When a patient is nursing, a bandage is used to support the breasts, and should they become painful, massage is used every four hours to distribute the milk evenly in the breasts. If there is not enough milk the patient should take milk, eggs, butter, and cream. If the breast becomes infected, massage is useful to remove the pus from the milk ducts; it should be given first lightly, then with more pressure, every four hours, with the use of the icebag between. When the skin becomes red and inflammation sets in the abscess must be opened and treated like an abscess in any other place. F.

A Contribution to the Ætiology of Chorio-epithelioma without a Primary Tumour in the Uterus.—Walthard (*Zeitschrift fur Geb und Gyn.*, Bd. LIX. Hft. 3) reports a case of chorio-epithelioma malignum occurring in the second half of a normal pregnancy of a woman, æt 27, who had previously been quite healthy. It was her fifth pregnancy, and from the middle of the seventh month she had suffered from hæmorrhage and a sanious discharge. The cause of this was found to be two polypoid growths about the size of hazel nuts with ulcerated surfaces which sprang from the anterior and posterior walls of the vagina. These were removed and examined microscopically. The diagnosis was chorio-epithelioma metastases. A Cæsarean section was consequently performed in the interest of the child, and was followed immediately by abdominal total extirpation of the uterus. The patient died seven months after the operation. The *post-mortem* examination revealed metastases, especially in both kidneys, in the lung and in the liver. Microscopical examination of the fresh uterus with the placenta *in situ* showed neither in the placenta nor in the uterus any appearance of a primary chorio-epithelioma of the placenta or of hydatidiform alteration in the villi. The microscopical examination, which was most thorough, had the same result. One may, therefore, conclude with certainty that even fatal chorio-epithelioma may extend to the different organs of a patient from the epithelium of the chorion or from the syncytium of the placenta without it being possible to find a primary tumour in the placenta either as a chorio-epithelioma, a hydatidiform or any other alteration of the placental cells. G.

The Recurrence of Carcinoma after Hysterectomy and the Treatment of Inoperable Uterine Cancer.—In a paper on this subject Hankel (*Zeitschrift fur Geb und Gyn*, Bd. LIX., Hft. 3) points out many unclear points which exist in the teaching regarding carcinoma uteri. He particularly wishes that one may be able to recognise from future reports on what grounds the different operators decide that operation is indicated, in other words, what cases are operable; and also in the different cases whether the carcinoma was primary in the portio or in the cervix. As regards recurrence the very rich material of the Berlin Klinik teaches the important fact, that, during hysterectomy for carcinoma, the glands need not be so very completely removed. If infiltrated glands are felt they are to be removed but unopened, because rupture of the gland capsule produces a greater danger to the patient than the retention of the carcinomatous glands in the abdomen. If the carcinoma is limited to the uterus, or is not extensively spread into the parametrium, the igni-extirpation of the uterus with, if it is necessary, Schuchardt's incision, is the best operation. The whole vagina or the greater part of it is to be removed at the same time. Every extensive infiltration of the pelvic connective tissue indicates laparotomy, as one can thus operate more radically. Every recurrence must be operated on if it is at all possible, and the earlier the better. In order to recognise recurrence at an early date the patients must report themselves regularly every ten to fourteen days. In cases of inoperable cancer the Paquelin and after that one of the usual caustics are to be employed. A single curetting and cauterisation of the carcinomatous tissue is not sufficient. The patients must remain under observation, and whenever necessary, the cauterisation is to be repeated. G.

Disappearance of Pregnancy: A Contribution to the Study of Hydatidiform Mole.—Polano (*Zeitschrift fur Geb. und Gyn.*, Bd. LIX. Hft. 3) records the following interesting case. The patient, æt. 28, had missed three periods. She had suffered from a bloody discharge for some days, and fever up to 39° C. To the left of the uterus, which was enlarged to the size of about four months' pregnancy, a soft tumour the size of half a fist was to be felt, so that a diagnosis of pregnancy of from three to four months, together with a left-sided pyosalpinx was made, at the same time the possibility of a tubal gestation was considered. The laparotomy revealed a distinctly pregnant uterus of from three to four months, the left ovary which contained many cysts enlarged to the size of half a fist, the right ovary smaller, but also cystic. Both tumours were removed, recovery was undisturbed, and there was no hæmorrhage from the uterus. When the patient was dismissed nineteen days after the operation the uterus was soft, but was certainly smaller than before the operation. The diminution in size continued without any appearance of hæmorrhage, so that nine months later a normal uterus 7 cm. in length by the Sound was to be palpated. As one cannot assume that a normal pregnancy at the third or fourth month thus completely disappeared, there only remains for this case the possibility that an abnormal product of conception had been present. This view is strengthened by the result of the microscopical examination of the ovaries which revealed the usual changes connected with hydatidiform mole formation. This case was therefore one of absorption of a hydatidiform mole which the author is inclined to believe was due to autolytic processes within the mole. G.

Hysterotomia Vaginalis Anterior.—Liepmann (*Med. Klinik*, 1906, Nr. 14) describes the technique of this operation, the vaginal Cæsarean section. Its chief indication is eclampsia. Since for this the author considers rapid and immediate delivery the best treatment, and as eclampsia usually sets in before or shortly after the onset of pains and usually that in primiparæ with rigid cervices, he considers that there is a wide field for this operation. In addition to this a series of placenta prævia patients were delivered by this method in Bumin's Klinik. It is also indicated in nephritis gravidarum, heart disease, lung disease, cicatricial stenosis of the cervix, carcinoma, premature detachment of the placenta, and even prolapse of the cord when the cervix is undilated. Dülussen's method of splitting the anterior and posterior walls of the cervix need not be performed, since it is possible to deliver large fully-developed infants by the one incision through the anterior walls of the vagina and uterus. The author's paper is the result of sixty-six cases, nineteen of which he had operated on himself. G.

MEDICAL NEWS IN BRIEF.

Tuberculosis in Ireland.

THE Women's National Health Association of Ireland, as already announced has organised a Tuberculosis Exhibition, on the lines of several held in America and on the Continent. The Exhibition will be open in the Home Industries Section at Ballsbridge during the last weeks of October, after which it is proposed to send it on tour to different parts of the country, beginning at Belfast, where a public meeting to inaugurate a branch of the Women's National Health Association is to be held about the beginning of November. The work of organisation has been in progress for some weeks, in the hands of a small Committee, under the presidency of Her Excellency the Countess of Aberdeen. A Consultative Committee is being formed, to which the leading medical societies and several public bodies have already appointed delegates. The meetings of the Committee are held at 76 Grafton Street, to which address any communications can be send to the Hon. Secretaries, Tuberculosis Exhibition.

THE QUESTION OF REPRESENTATION.

At the last meeting of the Public Health Committee of the Borough, a letter was read from the Women's National Health Association, asking the Public Health Committee to lay the matter before the Council, and to let them know if the latter would appoint two representatives on the Consultative Committee, to whom the scheme of the exhibition will be submitted for criticism and advice. The committee resolved: "That a copy of the foregoing communication be forwarded to the Local Government Board, with an intimation that the committee approve of the proposed exhibition, &c., and would be glad to appoint representatives to the Consultative Committee as requested; but, in view of their auditor's recent surcharges of the expenses of members attending meetings of associations not coming under the definition of 'conferences of local authorities,' they cannot see their way to authorise members to incur any expenditure in this instance, and they regret they must, therefore, abstain from being represented, unless the Local Government Board will authorise the outlay beforehand."

At yesterday's meeting the following reply from the Local Government Board was read:—"Local Government Board, Dublin, August 20th, 1907.—Sir,—I am directed by the Local Government Board or Ireland to acknowledge the receipt of your letter of the 15th inst., in connection with the attendance of delegates from the Corporation of Belfast, at the Tuberculosis Exhibition which is being promoted by the Women's Health Association; and I am to state that the Board are not in a position to give the Corporation the undertaking referred to in the conclusion of your letter. I am to point out that the auditor is bound under section 47 (2) of the Local Government Act of 1898 to surcharge payments made for any purpose not expressly authorised by statute.—I am, sir, your obedient servant, H. Courtenay, assistant secretary."

The Committee expressed their regret that under the circumstances they could not see their way to appoint representatives to act on the Consultative Committee of the proposed exhibition as requested, but intimated that if any of the members desired to attend at their own expense, the committee would facilitate them by giving them formal nominations to represent the Council.

Oyster Merchant Fined.

AT Colchester, on Saturday, William Bartlett, for 47 years an oyster merchant at Wivenhoe, was fined £20 and costs for selling Portuguese oysters which, according to the evidence of Dr. Klein, of St. Bartholomew's Hospital, were grossly polluted with sewage and contained an abundance of microbes. The prosecutors were the Wivenhoe Urban District Council, and Mr. Muskett, solicitor, watched the case for the Worshipful Company of Fishmongers. The Company's Chief Inspector stated that the defendant sold him the oysters from a bag, which was in such a position in defendant's yard that water from an adjacent sewer could flow over it. On receiving Dr. Klein's report, the district authority ordered the destruction of the defendant's remaining oysters and claimed a penalty against him for each unsound oyster, the total penalties claimed amounting to £160. The defendant had sent a sample of the oysters to D. Thresh, Medical Officer of Health for Essex, whose certificate stated that although not of a high standard of purity, the oysters were not grossly contaminated. The defendant stated that the oysters came from his pits at Tollesbury, and he and his family ate twenty-five for supper the night before the inspector called without harm resulting.

Mr. Morley and the Indian Government.

Following upon the King's letter comes an important blue-book despatch to the Governor-General written on July 26th. Mr. Morley says :—

"Your policy, in brief, is to rely for the present upon improved sanitation in towns, the co-operation of the people in the evacuation of villages, the destruction of rats, and such other measures as further investigations may suggest. You again consulted the Local Governments as to the expediency of constituting a special organisation for dealing with plague; but the reports of the Governments consulted are practically unanimous in condemning it as unsuited to Indian needs. Their reports are to the effect that suitable organisations for coping with the epidemic already exist, and that, although the executive may need strengthening in many cases, it is not desirable to strengthen it by importing medical men from England, who, being unfamiliar with the language and customs of the people, would not be qualified to direct measures which might involve interference with religious usage, and provoke a popular outbreak. The reports frankly recognise that the general sanitary service requires development, and that in this respect the needs of the times can be met by the employment of natives of the country. You state that proposals to this end are at present under your consideration. The fact that plague has been fatally active in India over eleven years, that the number of victims exceeds 5¼ millions, that its virulence is unabated and its progress uncontrolled, necessarily give rise to doubt as to whether everything that can be done has been done by the responsible authorities, and whether the last word of medical science and administrative skill has really been said. I wish with you that your efforts were attended with a greater measure of success. The conclusion expressed in the resolution of January, 1906, that 'in the last resort all preventive measures depend for their success upon the hearty co-operation of the people themselves,' while it defines the conditions of success, does not affect the obligation resting upon the governing powers of the country to endeavour to improve the quality of these measures, and win acceptance for them by skilled and considerate administration. I desire that no effort should be spared to arrest the spread of the disease by means acceptable to the people, and to give aid to the sufferers. I shall be glad to receive at an early date the proposals which are under your consideration for extending the general sanitary service by the increased employment of qualified natives of the country as medical officers of health and sanitary inspectors. Within reasonable limits of cost any proposals of the kind which you may submit will have my cordial support."

Medical Inspection of Schools.

Sir William Collins, on the 25th instant, asked the President of the Board of Education whether under the Education (Administrative Provisions) Bill there was any obligation on parents to submit children attending public elementary schools to medical inspection, as well as an obligation upon local education authorities to provide for such medical inspection.

Mr. M'Kenna: In the view of the Board the obligation placed by the Bill upon the authority to provide for inspection does not of itself compel a parent to submit his child to inspection.

Death of a Medical Man by Morphia Poisoning.

Mr. Walter Schroder conducted an inquest at St. Pancras, on August 24th, on Cyril Waldron Shaw, aged 42, bachelor, a doctor of medicine, found dead in bed at King's Cross, from the effects of morphia. The Rev. Seymour Shaw, Vicar of Warcop, stated that the deceased was his brother. He had been a good deal abroad in South Africa. He complained to witness of an abscess in the ear, which pained him acutely. Other evidence showed that Dr. Shaw complained to his landlord of a "maddening pain,' and wrote a prescription which he took to a neighbouring chemist, where he was supplied with twenty grains of morphia in a sealed packet Mr. Platt left him in bed on Wednesday night, and the next morning discovered him there lying dead. The bed-room door was unlocked. Dr. A. W. Dingley, Argyle Square; who had made an autopsy, said that no doubt Dr. Shaw had a severe pain in his ear, although there was no abscess. He suffered from bronchitis and alcoholism, and in his condition two or three grains of morphia would suffice to cause death. Death was due to morphia. A verdict of death by misadventure was returned.

St. Thomas's Hospital—House Appointments.

The following gentlemen have been selected as House Officers for the ensuing term. :—

Casualty Officers.—(Senior) W. O. Sankey, M.B., B.S.Lond., M.R.C.S., L.R.C.P.; (Junior), C. M. Page, M.B., B.S.Lond., M.R.C.S., L.R.C.P.

Resident House Physicians.—G. G. Butler, B.A. Cantab., M.R.C.S. L.R.C.P.; S. L. Walker, B.A., B.C.Cantab., M.R.C.S., L.R.C.P.; C. E. Whitehead, B.A.Cantab., M.R.C.S., L.R.C.P. (extension); H. G. Bennett, M.B., B.S.Lond., M.R.C.S., L.R.C.P. (*extension*); A. L. Loughborough, M.R.C.S., L.R.C.P.

House Physicians to Out-Patients.—W. H. P. Sutton, B.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P. (*extension*); S. Churchill, B.A.Cantab., M.R.C.S., L.R.C.P. (*extension*); B. T. Parsons-Smith, M.R.C.S., L.R.C.P.; A. J. S. Pinchin, M.B., B.S.Lond., M.R.C.S., L.R.C.P.

Resident House Surgeons.—H. J. Nightingale, M.B., B.S.Lond., M.R.C.S., L.R.C.P.; H. P. Unwin, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; G. M. Huggins, M.R.C.S., L.R.C.P.; F. M. Neild, M.B., B.S.Lond., M.R.C.S., L.R.C.P.;

House-Surgeons to Out-Patients.—H. H. Carleton, B.A., M.B., BCh. Oxon; R. E. Todd, M.B., B.S.Lond. M.R.C.S., L.R.C.P.; W. R. Bristow, M.R.C.S., L.R.C.P.; H. E. T. Dawes, B.A.Cantab., M.R.C.S. L.R.C.P.

Obstetric House Physicians.—(Senior) F. S. Hewett, B.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; (Junior) H. B. Whitehouse, M.B., B.S.Lond., M.R.C.S., L.R.C.P

Ophthalmic House Surgeons.—(Senior) A. S. Burgess, M.A.Cantab., M.R.C.S., L.R.C.P.; (Junior) A. I. Cooke, B.A., B.C.Cantab.

Throat.—R. G. Bingham, M.R.C.S., L.R.C.P.; A. W. C. Drake, B.A.Cantab., M.R.C.S., L.R.C.P.

Skin.—E. C. Sparrow, B.A.Cantab., M.R.C.S., L.R.C.P. (*extension*); J. F. Windsor, B.A. Cantab., M.R.C.S., L.R.C.P.

Ear.—W. H. G. Verdon, M.R.C.S., L.R.C.P.; W. Patey, M.R.C.S., L.R.C.P.

Children's Surgical.—W. A. Morton Jack, M.R.C.S. L.R.C.P.

Society of Apothecaries of London.

The following candidates passed the necessary examinations, and have been granted the L.S.A. Diploma of the Society, entitling them to practise medicine, surgery, and midwifery :—C. L. Driscoll and E. E. Wilbe.

A sixth edition of "The Pharmacopœia for Diseases of the Skin," by Dr. James Startin, has just been published by Messrs. John Wright and Co., of Bristol. This little work contains in condensed form much useful information about diseases of the skin, and many valuable formulas for their treatment. The author has also drawn up a few rules of diet and some general directions on the management of skin lesions, and the work is completed by a dermatological classification and a therapeutic index. Practitioners who have not yet met with the book in its previous editions will find the present one a pleasing addition to their therapeutic resources.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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D. R. H. — We are in accordance with the general opinion of the public on the subject, namely, that chicory is not injurious. If it had been, the fact must have been widely known long ere this. Occasional bad results have been reported, but these may be due to idiosyncrasy, or, what is more likely, to some other root having been accidentally substituted for chicory. The chemistry of chicory has not been much studied, we believe, but it is obvious that there can be no directly injurious substance present. It has little or no dietetic value.

R. P.—Your question is rather an odd one, but we are sufficiently versed in comparative anatomy to be able to assure you that dogs do suffer from sea sickness. Nor are they the only animals which do, for horses and cattle are subject to the malady too. The question was treated of in the spring by M. Landrieux, who read a paper before the Societé de Pathologie Comparée in Paris, in which he gave some striking instances. One fox-terrier puppy, eleven months old, fell an easy prey to the malady. The symptoms were practically the same as in man. Lack of interest in surroundings, dejection, salivation, and vomiting with rapid recovery on reaching *terra firma*.

L. K. Q. C. P. I.—The prizes (£25, £10, and £5) offered by Mr. George Sturge for authors of the best essays on "The Causes of Financial Depression in the Hospitals of London, with Suggestions for Improving their Administration in Finances," were proposed in August, 1886.

Podagra-Marlioz is a suburb of Aix-les-Bains, and connected therewith by a good omnibus service. It is only fifteen minutes' very pleasant shaded walk from centre of Aix. The three Marlioz springs are cold, alkaline, sulphurous, and bromo-iodinated. Their waters are *specially* efficacious for bronchitis (chronic, catarrhal, asthmatic), chronic diseases of the larynx. pharnynx, nose, ears, and uterus. The Marlioz Bath Establishment contains large inhalation-rooms, fine spray apparatus, and local douches for nose, throat, etc. Dr. Mace (of Aix-les-Bains) has published excellent articles and pamphlets on Marlioz waters and treatment. For further particulars write to the Director, Marlioz Baths, Aix-les-Bains.

A SUCCESSFUL FAT CURE.

We are not prepared to confirm or deny the last of the following statements from our contemporary, the *Pelican*, but if it be true we certainly agree that it is not "unfunny":—"That the various medicines for reducing the ultra-plump and making them sylph-like still continue to be very freely advertised and commented upon in singularly favourable fashion by the papers in whose columns the advertisements appear. That many of these preparations are dangerous things to take. That anyhow it is not an unfunny thing to reflect on the fact that the chief proprietor of a certain greatly advertised fat-reducer weighs over *twenty-two stone himself*—or did so last week!"

D. R. A.—The tumour may be malignant, but such growths generally occur in old-standing goitres. Carcinoma and sarcoma both occur; it is practically impossible to distinguish the two by merely clinical examination. Removal by operation can be undertaken, but the prognosis is not very rosy.

Tonus.—The question of pressing for payment must, we think, be left to your own judgment. If taken to court, we have no doubt twenty guineas would not be considered out of the way. That the patient expected that you would do the operation gratuitously would be no defence in law, unless there was a very clear understanding to that effect, as it is obvious that a man does not expect a surgeon in the ordinary way to do operations for charity. If you showed that he had reasonable means, we think you would be quite safe to recover.

Meus.—We do not know anything of the institution in question, and cannot therefore advise. It professes to be run on ethical lines, and may be genuine. There is a "fishy" look about it, we agree, and while there are other excellent institutions of the kind elsewhere, you would be well advised to go where you can repose confidence.

Pater.—Of course, the adding of a fifth year to the medical curriculum has made a difference in the fees charged by London hospital schools. Moreover, the larger number of practical classes has necessarily made study more expensive. In the old days the composition fee was roughly a hundred guineas, if paid in one sum, and about £120 if paid by instalments. As we said last week, the average composition fee is now about £130 or £140.

Vacancies.

Mickleover (Derby) County Asylum.—Junior Assistant Medical Officer. Salry £120 per annum, with furnished apartments, board, washing, and attendance. Applications to Dr. Legge.

West Herts Infiramry, Hemel Hempstead, Herts.—House Surgeon. Salary £100 per annum; rooms, board, and washing found. Applications to the Rav. W. T. T. Drake, Boro' Gate, St. Albans.

Bedford County Hospital.—House Surgeon. Salary £100 per annum, with apartments, board, and laundry. Applications to W. F. Morley, Secretary.

Edmonton Union.—Assistant Medical Officer. Salary £180 per annum, and £40 per annum in lieu of residential allowance. Applications to F. Shelton, Clerk, White Hart Lane, Tottenham.

Toxteth Park Township.—Assistant Resident Medical Officer. Salary £100 per annum, with board, washing, and apartments. Applications to R. Albert James, Clerk to the Guardians, 15 High Park Street, Liverpool.

Bridgnorth and South Shropshire Infirmary.—House Surgeon. Salary £100 per annum, with board and lodgings in the Infirmary. Applications to the Hon. Secretary, the Infirmary, Bridgnorth.

Egyptian Government.—Kasr El Ainy Hospital.—Resident Medical Officer. Salary £250 a year, with quarters, servants, washing, coal, and light. Applications to the Director-General, Public Health Department, Cairo.

Egyptian Government.—Ministry of Education.—School of Medicine, Cairo.—Assistant to the Professor of Pathology. Salary £E.320 per annum. Applications to the Director, Government School of Medicine, Cairo, Egypt.

Loughborough and District General Hospital and Dispensary.—Resident House Surgeon. Salary £100 a year, with furnished rooms, attendance, board, and washing. Applications to Thos. J. Webb, Secretary, Loughborough.

Scarborough Hospital and Dispensary.—Senior House Surgeon. Salary £100 per annum, with residence, board, and allowance for laundress. Applications to the Hon. Secretary.

Wallasey Urban District Council.—Medical Officer of Health. Salary £500 per annum. Applications to H. W. Cook, Public Offices, Egremont, Cheshire.

Barnsley.—House Surgeon. Salary £100 per annum, with board and lodging. Applications to R. F. Pawsey, Honorary Secretary, Barnsley.

Leicester Corporation.—Isolation Hospital.—Resident Medical Officer. Salary £120 per annum, with board, lodging, and washing. Applications to C. Killick Mallard, M.D., Town Hall, Leicester.

Leicester Parish.—Resident Assistant Medical Officer. Salary £120 per annum, with rations, furnished apartments, and washing. Applications to Herbert Mansfield, Clerk to the Guardians, Poor-Law Offices, Leicester.

London County Asylum, Long Grove, Epsom, Surrey.—Fourth Assistant Medical Officer. Salary £180 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk to the Asylums Committee, Asylums Committee Office, 6 Waterloo Place, S.W.

Appointments.

Ball, W. Girling, F.R.C.S.Eng., Assistant Surgeon to the City of London Truss Society.

Gask, G. E., F.R.C.S.Eng., Surgeon to the City of London Truss Society.

Gorham, P. C., L.R.C.P. and S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Clifden District of the County of Galway.

Harvey, Frank, M.R.C.S., L.S.A., Public Vaccinator for the St. Issey and St. Breock Districts by the St. Columb (Cornwall) Board of Guardians.

Hustler, G. H., M.B., Ch.B.Leeds, Government Medical Officer for Fiji.

Niven, A. M., M.B., Ch.B., on the Resident Medical Staff of the Royal Infirmary, Aberdeen.

Stewart, Alex., M.B., Ch.B., on the Resident Medical Staff of the Royal Infirmary, Aberdeen.

Walford, Harold R. S., M.R.C.S., L.R.C.P.Lond., Assistant House Surgeon at the Coventry and Warwickshire Hospital, Coventry.

Marriage.

Dowden—Oswald.—On August 21st, at St. Mary's Cathedral, Edinburgh, John Wheeler Dowden, F.R.C.S.E., to Edith Georgiana, younger daughter of the late Surgeon-General H. R. Oswald, I.M.S.

Deaths.

Antrobus.—On August 22nd, at The Chase, Great Malvern, Edmund Antrobus, M.D., aged 45.

Margrave.—On August 10th, at Moffat, N.B., Malcolm Llewelyn Margrave, M.R.C.S., L.R.C.P.Lond., late of Llanelly and Newton Abbott, aged 42 years.

Maurice.—On August 20th, at the Vicarage, Isleworth, Benjamin Maurice, M.R.C.S., L.S.A., of 12 Osborne Road, Clifton, Bristol, son of the late William Maurice, of Clifton, formerly Surgeon to the 7th Hussars.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, SEPT. 4, 1907. No. 10

NOTES AND COMMENTS.

Small Holdings. AFTER a full and eventful session, Parliament rose last week, leaving behind it an amount of completed legislation of considerable and varied importance. The session is notable among many other things for the number of measures dealing, directly or indirectly, with public health and medical polity. Foremost among these stands the Small Holdings and Allotments Bill, which in principle was uncontroversial, though in practice its details came in for a good deal of criticism. If the anticipations of the promoters and supporters of this measure are realised, it may have exceedingly far-reaching results on the physique of the nation, for it will bring into existence a large class of peasant tillers of the soil, than whom no hardier and more virile men can be found. The nation which consists principally of town-dwellers is obviously a nation living under conditions not conducive to the best physical development, and the population of large towns such as are growing with apparently irresistible force in England, is bound sooner or later to lose the sturdy qualities that the wrestle with the land under sun and hail bring out and keep alive. We are hardly sufficiently optimistic to expect that this new Act, or even a series of similar ones will greatly change the current economic factors, but it is just possible that it may establish in this country a class of public tenants who will be available as a source of recruiting for townsfolk, and that thus a good backbone of physical resource will be created. At any rate, the Act is beneficent and praiseworthy in intent and it is only a pity that a technical detail of administrative arrangement should have prevented Scotland enjoying similar opportunities.

Education (Administrative Provisions). THE next most important achievement of the session has been the passing into law of the Education (Administrative Provisions) Bill, and it has shown Mr. McKenna to be possessed of a quality rare in politicians, namely, that of fulfilling in fact more than he would promise in prospect. This bill again was practically non-controversial, especially as the details had been pretty well thrashed out last year in Mr. Birrell's ill-starred and more comprehensive measure. By this Act the Board of Education are authorised to organise the work of medical inspection of elementary school children throughout the country, and the birth of school hygiene may now be looked upon as an imminent event. If we may be allowed to offer advice on this subject we would of all things implore the President of the Board of Education to beware of the faddists in making his arrangements for this duty. There is a large class of unmarried ladies of unimpeachable motives and of elderly bachelors read in the schools of Tübingen who, by reason of their interest in the subject of the education of children, are looked upon as "experts." May Mr. McKenna eschew such "experts"! The science of school hygiene is yet in its infancy and has little of technical lore of its own. It is yet, and is likely for many a day to be, but the sanctified commonsense of a wise physician who is acquainted with hygiene and acquainted with children. The headquarters medical staff will be effective or ineffective in creating an effective administration of the provisions of the new Act in so far as they are not committed to any scheme of Scandinavian gymnastics, exotic anthropometry, or other doctrinaire panaceas. The British child is a person who likes play, dislikes book-work, and is subject to certain ailments. His salvation may be worked out largely by attention to his limitations.

Public Health Acts. ANOTHER beneficent measure is the Public Health (Regulation of Food) Act, which has safely found its way to the Statute Book. As we have often pointed out in these columns the outburst of indignation against Chicago was largely an outburst of ignorance, the people of this favoured land fondly imagining that all their food was of the best in the best of all possible countries. On the contrary, the amount of bad and diseased food openly and covertly trafficked in is enormous, and the safeguards provided by law, the seizure of unsound food intended for the food of man by the health officials, and its destruction by magistrate's order, largely illusory. The respect of the Constitution for the sacred rights of property is no less exhibited in practice than in legislation, and not only is it difficult to prove the food is intended for the food of man, but magistrates are often extremely lenient to owners of such food. Now, however, the local authorities have far larger powers of inspection and control over food supplies and places where food is kept, and it may confidently be anticipated that, if properly used, there will be far less ill-health and death from the consumption of offal of various kinds which has been refused by the stricter regulations of foreign countries and dumped on these shores. Mr. Burns also got through another Public Health Bill, and his Vaccination Bill for tempering the wind of magisterial criticism to the shorn conscientious objector, and the Secretary for Scotland, besides performing the latter service also for his country, obtained a small but needful change in its own Public Health Act.

Notification of Births— OF the Notification of Births Act it is difficult to write temperately. In object it is praiseworthy enough, for it aims merely at giving the medical officer of health early information of births in his district, so that he may be in a position to take steps to see that the children are properly cared for by their mothers in the first few days of their lives. Whether the steps taken will conduce to that desirable end naturally remains to be seen, but the point which affects medical men, and which we dealt with at length in our leading columns last week, is that it places a new and definite obligation on private medical men pursuing their profession, without fee and yet *with* penalty in default of the father notifying. The time really seems to be ripe for some definite movement among members of the profession for letting the public know that while they are willing and anxious to promote the public weal in every reasonable way, they do object to be constituted informal spies on their patients, and they do object to be laden with responsibilities which may land them in the police-court, and for which they receive no compensation. The habit of regarding the medical man as a beast to bear the communal burden is growing alarmingly. The Midwives' Act made him responsible, of course without payment, to hold himself in readiness to obey the summons of every midwife who found herself in difficulties, without giving him any control over the midwife's practice. The indignity thrust on him by this new Act is scarcely less, and to prate in high-falutin' style about doctors' benevolence is only to take an unconscionably mean advantage of the present private charitableness of medical men. Were the appeal made to medical benevolence and to that alone, a response, we believe, would be forthcoming, but a police-court penalty is an abominable outrage.

And other New Acts. As to other Acts, we, as members of a working profession, have to thank the Chancellor of the Exchequer for the relief granted in the income-tax. It has always been a patent anomaly that the worker should be taxed at the same rate as the drone, and though, as in all enactments, there will be certain hard cases, the broad principle of preference for the earner as against the beneficed is now established. Medical men will wish all possible success to Mr. Asquith's cleek and gun during the next few months. They will perhaps not care much one way or the other as to the measure which enables women to sit on local bodies. Theoretically the gentle influence of the sex should have play in the sphere of minor government, but it is a rather common experience to those who have served on and under such boards that though many excellent ladies have done good work on them in the past, there is an unfortunate tendency for the Martha rather than the Mary variety to seek municipal honours. With the growing interest in local government, let it be hoped the electors will learn to discriminate between their respective qualifications.

Great Wyrley Outrages. THE fresh series of cattle outrages at Great Wyrley lends confirmatory evidence, if any were needed, to the innocence of George Edalji of the crime with which he was originally charged, and we believe there are few people now who believe him guilty, even in the neighbourhood where prejudice against him is very strong. Whether the police or Sir A. Conan Doyle, or both, succeed in nailing the real malefactor, the fact remains that an innocent man has already suffered for a crime which it was obvious all along to scientific minds he had not committed. The question has been discussed over and over again in these columns, but the share taken by the MEDICAL PRESS AND CIRCULAR in protesting against the Edalji conviction, and petitioning for his release has been eclipsed and forgotten in the sensational events of the last few months.

LEADING ARTICLES.

AN EXPERIMENT IN SCHOOL MEDICAL INSPECTION.

THE question of the medical inspection of schools has of recent years come definitely within the range of practical politics. On all hands its importance has been recognised not only as a means of checking the spread of communicable diseases, but also of controlling the physique of rising generations and of supervising the conditions of school environment. An important experiment in this direction has been made by Dr. Myer Coplans, Medical Inspector of Schools, Gloucestershire Education Committee, who communicated a valuable paper on the subject to the recent International Congress of School Hygiene. The local County Education Committee in question desired to improve the condition of certain elementary schools in which the attendances, and, consequently the grant-earning capacity, had been seriously impaired by reason of the continued prevalence of contagious skin affections among the scholars. Under then-existing legislation, however, there were no statutory powers enabling an official medical examination of the children to be made without the consent of parents. It therefore became necessary to devise some means of ascertaining the facts of the case as regarded the skin diseases mentioned, at the same time respecting the rights of the parents. This difficulty was overcome by Dr. Coplans circularising the parents of some 8,000 children, with the result that 97 per cent. of them agreed to his proposals. His plan was to issue a card, which was intended to accompany the child through his or her school life. On one side of the card were particulars filled in by the parents concerning the child's ailments, the medical history, and questions as to tuberculosis in the family. On the other side were notes made by Dr. Coplans at regular intervals concerning the child's physical and mental development, condition of skin, state of vaccination, together with remarks when necessary on the special senses. For each of the sixty schools under observation there was instituted a medical register in which was tabulated standard by standard the condition of individual scholars as shown by the card. He found the columns relating to the records of zymotic disease of great assistance in determining the probability of spread of any particular form of disease in any standard, department, school, or even village, and he recalled one case of a village concerning which the columns relating to measles showed at a glance that there had been no instances of that disease for more than seven years. He was therefore prepared to advise school closure on the appearance of the first case of measles in that particular village. The advantages of the scheme thus outlined are conspicuous. One of the chief recommendations is the continuity of record which is secured in the case of each individual child. Further, an accumulation of statistical data would be secured that could hardly fail to be of the greatest value in the future study of the complex conditions of school life. Early and continuous information, moreover, would be furnished of affections of the special senses, and of those abnormalities of mind and body which render a separate classification imperative in any well-organised educational system. So far as private schools are concerned, it may be anticipated with a fair amount of confidence that it is only a matter of time for them to fall into line with the movement that is now being established in State schools. Probably one of the chief obstacles in the way of general medical inspection will result from financial considerations. In dealing with infectious diseases, notification alone is useless without the corollaries of isolation and disinfection. So in educational life medical inspection without accompanying powers and available classifying and remedial agencies, would be of little value. It is one thing to inspect the eyesight of a million of school children, but another matter altogether to provide spectacles for those who need them. A similar observation, *mutatis mutandis*, applies to other physical and mental defects. As a sound contribution to the attack on a complicated problem, Dr. Coplans' Gloucestershire experiment is worthy of the attention of the medical profession.

CURRENT TOPICS.

Value of Science in Montgomery.

There are few counties which have yet recognised the value of the powers their Councils are endowed with for appointing medical officers of health. There are, however some which have availed themselves of the privilege, and though the salaries paid are seldom such as to entice men from other posts, in some counties the medical officer of health is paid a moderate living wage. Of late a new plan has been adopted by a number of these authorities which desire to be considered at once enlightened and economical, namely, to appoint as medical officer a man engaged in other work and to pay him a small salary and certain fees for such work as the Council commission him to do. The salary is usually exceedingly small and the fees nominal, but the county escapes the reproach of not having a medical officer of health. As the result of the pressure of public opinion, the Montgomery County Council have decided that they, too, shall have a medical officer of their own; so they have advertised for one and laid down an elaborate scheme of duties for the successful candidate. The salary was not specifically stated, but it turns out that these responsible and arduous duties are to be performed for the ambassadorial salary of five-and-twenty guineas a year! How such a post is to attract anyone who proposes to do his work thoroughly no reasonable person can conceive, and it is absurd to suppose that anything but the most nominal compliance with any of the specified rules is required. In a word, the policy of the Montgomery County Council appears to be one of throwing dust in the eyes of the public by swaggering off a medical officer of health, when for all practical purposes such an officer does not exist. County medical officerships should be among the prizes of the profession, and should be paid so as to attract the very best men; in hardly any county is their salary more than moderate, but in Montgomery it is farcical.

Inebriates' Homes.

The report for last year of the Inspector under the Inebriates' Act has just been issued, and it is as careful and suggestive as usual. It is noticeable that whereas the number of men committed to institutions under the Act has increased from 91 to 110, the number of women has fallen from 352 to 294. There have been many signs lately that magistrates are losing faith in inebriate retreats for women, and it is not altogether surprising that this should be so, for the number of "cures" is exceedingly few. The reason for this is that prisoners can only be committed after four convictions within a year, and this safeguard to individual liberty successfully assures that none but the most confirmed inebriates are arrested. Now, with all respect to individual liberty, it is beyond reason to expect cures or any efficient reclamation among women of this class, and it is not wonderful that magistrates are getting to lose faith in retreats and to send fewer women to them. It is a striking fact, as shown in the inspector's report, that three-quarters of the crimes perpetrated under the influence of drink for which women are committed, consist in neglect of children. The numbers actually are 291, out of 364 total crimes. Of the other crimes, those of violence are remarkably small, there being only one conviction for manslaughter, two for malicious wounding, and seven for assault. At the present day, when so many beneficent measures are taken to promote temperance, it is a pity that the law does not give greater opportunities to officials to enter the homes of drunken mothers and protect the children.

Alcohol and Mountaineering.

No better example of the altered attitude of the public mind toward the use of alcohol can be adduced than the fact that it is rapidly passing out of use by mountaineers. It is but a few years since brandy was regarded as a requisite in every climbing expedition, and it was a rash climber who ventured out without it. Nowadays, it is not used at all as a beverage while climbing, and it is only carried for use in case of accident or to sustain life in case of prolonged exposure. Dr. Schneider, an Austrian physician, has recently administered interrogatories to some 1,200 climbers with a view to discovering their experience and opinions based on their personal use of alcohol. They are practically agreed in believing that alcohol should be reserved for special occasions, and is to be regarded as a hindrance rather than as a help in the ordinary course of climbing. This is, indeed, what might be expected, when it is remembered that there are few occupations which demand a truer eye, a steadier nerve, and a cooler head than does mountain-climbing. The beverages which have taken the place formerly occupied by alcohol are cold tea and cold coffee, which are stimulating and refreshing without possessing the incoordinating effects of alcohol. We have no doubt that another few years will see the disappearance of the brandy-flask from the hunting-field as it has already gone from the glacier and the rock.

Deaths Under Anæsthetics.

THE proportion of deaths under general anæsthetics, as already insisted upon in these columns, varies in different hospitals to such an extent as to suggest the desirability of careful scientific investigation. That there will always be an irreducible minimum of fatalities under such circumstances appears to be more than likely. There are certain obvious points that are capable of reduction to systematic and detailed statement, such as, for instance, the experience of the administrator, the nature of the anæsthetic, and the kind of apparatus used in each given case. In some quarters it is customary to assume that ether is absolutely safe, and writers upon chloroform deaths are wont to ignore deaths from the former drug. Attention may be drawn to a case reported in the news columns of our present issue, in which death resulted after four ounces of ether had been administered. Dr. Waldo, the City of London Coroner, has taken up the question of deaths under anæsthetics with his usual vigour and thoroughness, and we may hope for extended and authoritative investigation on a point of the utmost practical importance, not only to medical science but also to the welfare of the public.

Opening of the New Wing at the Rotunda Hospital, Dublin.

THE new wing, which has been lately added to the Rotunda Hospital, was formally opened on Tuesday of last week by Her Excellency Lady Aberdeen. The new wing adds to the older buildings six additional wards, by setting free the entire top-floor of the Plunkett Cairnes Wing, which up to this had been used as a nurses' home. It also provides a new lodge, and residential quarters for lady students, a disinfecting chamber for bedding and patient's clothes, and an ample supply of bath-rooms and lavatories. The Master of the Hospital, Dr. Hastings Tweedy, in the course of the statement with which the proceedings on Tuesday commenced, referred to the urgent need which existed for providing additional accommodation on the midwifery side of the house. The number of applicants for admission has increased enormously, with the result that the existing wards are overcrowded. The Rotunda Hospital has always boasted that no patient has ever been turned away, but had it not been for the new wards such a course would inevitably have had to be adopted. The new wing, which connects the central portion of the hospital with the lodge, cost over £8,000, and by its completion the claim of the Rotunda Hospital to be in the first rank in the United Kingdom, both in its accommodation for patients and for students, is made more patent than ever. The Master of the Hospital deserves the very greatest credit for the energy which he has shown in bringing about this new addition to his hospital.

Tuberculosis and Work on Farms.

THE problem of the eradication of tuberculosis, like many other social matters, is more or less closely associated with the land question. Other things being equal, it can hardly be doubted that country air is far less conducive to tubercular affections than that of towns. So far as actual treatment is concerned, open-air sanatoria are available for only a small proportion of consumptives. Under present conditions the cost of maintaining such patients indefinitely is simply prohibitive to local authorities. Any proposal, therefore, which suggests any way out of the difficulty deserves the earnest consideration of sanitarians. From this point of view Dr. Robertson, the Medical Officer of Health at Leith, makes a practical suggestion that is worth attention. Dealing with the difficulty of effecting cures in the majority of cases of tuberculosis, he expresses an opinion that what we really want is farm accommodation where patients, after a specified period of residence in hospital, may be sent to work in the open-air for several months. This proposal is excellent from various points of view. It would, for instance, not only be the best of all occupations for the patient, but it would isolate the infection in a place where it would be harmless, and would supply the farmer with labour at moderate wages. It is not unlikely that the system of farm colonies has a future in various maladies other than tuberculosis. Under good management the plan might be made to a great extent self-supporting.

Medical Man Shot Dead by a Lunatic.

THE special perils of medical professional life have been once again demonstrated by the tragic murder of a medical man in Leeds. With much regret and sympathy we have to record the fact that on Saturday last Dr. Walter C. Hirst, of Chapeltown, Leeds, was shot dead on his own doorstep by a man named Harrison, who immediately afterwards shot himself. It appears that the assailant had been attended by Dr. Hirst for a week or so for some affection of the brain, and was about to be certified for admission to a lunatic asylum. A letter sent by Harrison to a friend shows that he was the victim of delusions. It refers twice to the fact that the doctor struck him on the knees and knee-caps, and asserts that the proceeding in question brought on "terrible epileptic fits." The man went to the house at six o'clock in the morning, when Dr. Hirst, thinking the servants would not be up, went down to the door himself, and instantly received two shots from a revolver through the front of the chest. There were no eye witnesses of the event, but both bodies were found a few minutes later lying about five yards apart. Dr. Hirst was 28 years of age, and had been married only three months. The delusion as to the blows on the knees appears to have arisen from the ordinary testing of the activity of the knee-jerks. Fuller details of the tragic occurrence will be found in our news columns.

Notification of Epidemic Cerebro-spinal Meningitis in London.

Some time since we ventured to predict that the invasion of London by epidemic cerebro-spinal meningitis was simply a matter of time. The gradual spread of the malady in Ireland, Scotland, and certain provinces in England suggested that inevitable conclusion. The recent occurrence of several cases in the metropolis tallies with the usual history of invasion in in which these herald cases are the invariable precursors of an extended outbreak. The gravity of the position appears to be recognised by the London County Council extending the notification of this special form of meningitis for eighteen months further from September 13th, 1907, the date of expiry of the present order. It is expressly intimated that the term "cerebro-spinal fever" does not include meningitis due to tuberculosis, syphilis, middle-ear disease or injury.

The Tuberculosis Exhibition in Dublin.

The main features of the scheme for the Tuberculosis Exhibition, which is being organised by Her Excellency the Countess of Aberdeen, were put before a meeting of the Consultative Committee last week, and met with cordial approval. The Consultative Committee consists of representatives of the various public health authorities, of the various medical corporations and societies, and of other bodies likely to be interested in the matter, and Lady Aberdeen has acted with her usual wisdom in thus enlisting the sympathy and interest of many representative men. The present plan is that the exhibition, which is to open in October, shall consist of seven sections: "Diagrams and Statistics," "Pathological and Bacteriological," "Dietary," "Literature," "Appliances bearing on Treatment," "Veterinary," and "Lectures and Demonstrations." Each section is in the hands of an organiser, and the list of organisers shows a very careful and proper selection. Among them are the Registrar-General, Dr. Alford Boyd, Dr. Lily Baker and Professor Witham, of the Royal Veterinary College. The organisers gave to the Consultative Committee brief sketches of their plans, which were sufficient to show that the exhibition cannot fail to have educative effects of great importance in many directions.

PERSONAL.

Major V. H. W. Davoren, from Devonport, has taken over the duties of Medical Officer at Bury St. Edmunds, *vice* Lieut.-Col. R. Anderson, F.R.C.S.Edin., retired under the age clause.

Dr. M. Cameron Blair has been promoted to be senior medical officer in Southern Nigeria. Mr. W. H. Langley, C.M.G., has been appointed principal medical officer of the Gold Coast.

Dr. E. I. Spriggs has been elected Dean of St. George's Hospital Medical School.

At St. George's Hospital the Medical School Committee have decided to place a brass tablet in the new pathological laboratory in memory of the late Dr. Robert Barnes.

The death of Dr Seneca Powell, of the New York Post-Graduate School of Medicine, is attributed to his investigations into carbolic acid poisoning He had frequently experimented on himself, and this is believed to have undermined his constitution.

Dr. Henri de Rothschild, who goes out to Tangier in charge of the hospital he is to establish there, is the elder of two sons of the late Baron James Edward de Rothschild, of London, who, in his turn, was the elder of the two sons of Nathaniel, the third son of Nathan Mayer, the founder of the English house. The Rothschild hospital in Paris, which he superintends and works by himself, is open to all, irrespective of religious creed. About nine months ago he added to his other benevolences the gift of 100,000 francs to start a Cancer Research Institute.

Sir T. Lauder Brunton will deliver the inaugural address of the winter session of the London School of Tropical Medicine, on Monday, October 21st, when the chair will be taken by Mr. R. L. Antrobus, Assistant Under-Secretary of State for the Colonies.

Earl Grey, Governor-General of Canada, recently opened a consumptive sanatorium in Toronto, to be known as the King Edward Sanatorium.

Director-General Sir Alfred Keogh, K.C.B., has been appointed Honorary Physician to H. M. the King.

Much to the regret of the Executive Committee of Winsley Sanatorium, Dr. Lionel Weatherly has resigned the chairmanship on the grounds of ill-health and his removal to Bournemouth.

Dr. Moure, the famous Bordeaux surgeon, will in a few days be summoned to the Miramar Palace, where he will operate on King Alphonso for adenoids.

We beg to offer our warm congratulations to Sir Henry Alfred Pitman, who has just entered upon his one-hundredth year, and is the oldest physician in the United Kingdom. Sir Henry took his M.D. at Cambridge in 1841. From 1858 to 1889 he was Registrar of the Royal College of Physicians, and is still the Emeritus Registrar. Sir Henry, who enjoys good health, and is very active considering his great age, resides at Enfield.

A Clinical Lecture
ON
ABORTIVE FORMS OF TABES.

By PROFESSOR F. RAYMOND, M.D.,

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[SPECIALLY REPORTED FOR THIS JOURNAL.]

Physicians who have opportunities of studying cases of locomotor ataxy and of observing them over long periods of time are forced to the conclusion that the classical description with which text-books have familiarised us does not cover the whole ground. Each patient makes a selection, so to speak, from the symptomatology and presents a special group of symptoms which thereupon assumes an individual aspect so that no two tabetics are exactly alike.

This polymorphism is particularly misleading in the præataxic period. It is indispensable that we should be acquainted with the various forms in which the disease may present itself at the onset, and I propose to discuss three cases in which the diagnosis offered some difficulty.

Our first patient is a woman, æt. 37, a dressmaker, whose past history is pathologically uninteresting, except that she admits alcoholic excesses. One afternoon last winter she was returning home on foot when she noticed a sudden numbness which started in the left foot, gradually extending to the whole limb, then spread to the hand and arm, in short, all the left side of the body except the face was similarly affected. The side seemed "dead" and felt very cold. She felt giddy and had to lean against the wall to avoid falling down. It passed off in about ten minutes and she went home.

Three days later the same thing occurred, but this time on the right side, when the face and tongue were affected. For a few minutes she was unable to speak and had to lean against a wall, but again in a few minutes the sensation passed away. Four days later, still in the afternoon, she had a similar attack at home, the face not being involved.

She has had no further recurrence of the symptoms, but at every sudden movement she feels jerks and trembling in the left foot, and more recently a tremor of the left side of the face. These are the symptoms that brought her to the Salpêtrière. Her general health is good, she does not suffer from headache or disturbances of the special senses and motility is perfect.

Now this patient presents none of the stigmata of the neurotic subject, nor a trace of hysteria, and if I raise this question it is only in order to impress upon you that you must never omit to ask yourselves the question, in presence of nervous manifestations, whether these are not purely functional.

The organic origin of these symptoms having been established there is only one term to describe a sensory crisis which starts at the distal end of a limb, spreads all over the body and ends in a brief lapse of consciousness, *viz.*: Jacksonian epilepsy. This term may suggest to you the idea of a convulsive motor manifestation, but such attacks are often preceded or accompanied by sensory phenomena, pain, numbness, tenderness, etc. This localised epilepsy may indeed assume a purely sensory form of which I have seen numerous instances, mostly followed by an "absence of mind" or vertigo, rather than by comatose loss of consciousness with stertor. This case belongs to the latter category.

The pathogenesis of the syndroma has not as yet been cleared up, but we know at any rate that the cause must be looked for in irritation of the grey cortex in the sensory motor zone. In this patient, however, we do not at first sight find the ætiological factor which would explain this irritation. She has had no recent or previous injury to the cranium since there is no headache, no vomiting, no vertigo, no ocular phenomena. It is not an exogenous intoxication, there is neither diabetes nor renal inadequacy. In fact we have no objective sign to guide us so we must trust to close examination of the patient to reveal some symptom which will put us on the track of the underlying cause, for though it is not mechanical or toxic it may be reflex or vaso-motor.

The woman tells us that she has no trouble in walking, and, as a matter of fact, on superficial examination, her steps are regular and she even walks straight. But if we make her turn round suddenly or tell her to go down stairs without looking at her feet she is embarrassed and hesitates. In the erect position too, things look normal, yet when she is told to stand on one foot she sways, showing a disturbance of equilibrium. There is then some slight incoordination, and this constitutes Romberg's sign.

Muscular strength is intact in all her limbs, but when she is told to shut her eyes and put a glass to her lips she goes wide of the mouth. Let her try to place the left heel quickly on the right knee—she cannot do it! These are the means which enable us to diagnose ataxy at the onset.

We may add that the ankle and knee jerks are abolished and those of the upper limbs are very feeble. There is nothing wrong with objective sensibility, but the area of the ulnar nerve is hyperæsthetic. Lastly, examination of the eyes reveals two signs of the greatest importance, the Argyll-Robertson pupil on the one hand and, on the other, traces of old standing optic neuritis, manifested by irregularities and pallor of the optic nerves. One little detail to complete the picture—for no point must be overlooked—she has false teeth and she tells us that some years ago her teeth became loose and in a short time came out though not decayed. This shedding of the teeth is evidence of a trophic disturbance comparable with shedding of the nails, perforating ulcer, etc., and it is a comparatively rare sign of the disease under consideration. In view of these various signs we need not hesitate to diagnose Duchenne's disease, but it is not yet true locomotor ataxy for the patient is still in the pre-ataxic stage.

Now, among the abnormal manifestations of tabes are certain cerebral symptoms which as a rule occur during the præ-ataxic period, *viz.*: apoplectiform or epileptiform attacks which may resemble complete essential epilepsy or Jacksonian epilepsy, hemiplegia or localised paralysis, which have this in common that they all exhibit a tendency to clear up rapidly and spontaneously. This fugitive character justifies us in putting them down to vaso-motor disturbance, possibly dependent upon medullary or protuberous lesions of tabes.

However this may be, these symptoms suggest a malady affecting the cerebrum. You cannot but be struck by the unlikeness of the principal medullary type of tabes. If you bear in mind the extremely insidious invasion of these symptoms you will understand how easy it is to make a mistaken diagnosis of some cerebral disease, cerebral syphilis, etc.

There is one other point to which I must call attention; among the somatic troubles of the prodromal period of diffuse meningo-cephalitis one of the most important is the sudden, unexpected supervention of epileptiform attacks, either general or local. These may be motor or sensory, but the latter possess a special significance and must be looked upon as one of the most characteristic signs of the onset of progressive general paralysis.

Now in this woman we shall find that certain symptoms accompanied her attacks of sensory epilepsy which escaped our attention just now, *viz.:* a little trembling of the tongue a little "mouthing" and some blurring of words. Though but slight these signs must make us hesitate awhile as to the diagnosis. I should not be surprised indeed, if, within the near future, this woman gave unequivocal signs of general paralysis.

This is not the moment to enter upon the discussion of the relationship of general paralysis to tabes. This view was first suggested in France by Baillarger, and the co-relationship was set forth by my pupil, Dr. Nageotte, in his thesis, under the term "Cerebro-Spinal Tabes," a term which Dr. Fourrier gives to cases in which the two manifestations run their course together.

We will now pass to the second patient, a strong man, æt. 39, who is still employed as a messenger. He comes to us for chronic, recurring ulceration of the soles of both feet, which started eight years ago. When 31, he had a perforating ulcer on the right little toe which led to painful suppuration and was followed by the shedding of two phalanges. Five years ago another ulcer formed on the first phalanx of the left big toe. There is another on the metacarpo-phalangeal joint underneath. Another similar ulcer, this time associated with symptoms of general infection, occurred on the left little toe, and the third phalanx came away. A fifth ulcer started in 1902 on the right big toe, necessitating amputation and last year a sixth made its appearance on the fifth left metatarsal bone. There is very distinct perforating ulcer on the left foot, there is a circular loss of substance with punched-out edges made up of stratified epithelium, and the base is irregular and granular and is bathed in scanty muco-purulent secretion. There is no inflammatory reaction round the ulcer, it is everywhere anæsthetic, and the sound touches bare bone and can be pushed right into the joint, the synovial membrane whereof is thickened and granular. Then, too, the feet are cold and livid and the skin is covered with cold sweat. There is some œdema in the left leg and the skin of both feet shows a tendency to hypertrophy.

Since Nélaton first described what we now know as perforating ulcer, its pathogenesis has undergone many modifications. Without troubling you with the history of the question I may state that the affection is no longer looked upon as a purely local lesion due to mechanical causes. Some, Péan, for instance, ascribe it to arterial lesions, others, like Poncet, Duplay, and Morat, believe it to be of nervous origin and attribute it to degenerative changes of the nerves. The latter view is the one that holds the field at present, so that we need not waste time in the endeavour to elucidate a mechanical ætiology. That prolonged pressure may be a determining and localising factor is but probable in view of the improvement that follows rest, but the fundamental trophic disturbance must be looked for elsewhere. First we must look to diseases of the spinal cord, especially tabes, then infantile paralysis, Freidreich's disease, myelitis, syringomyelia, etc. Perforating ulcer may even be one of the trophic disturbances affecting the foot consequent upon medullary compression, as in Pott's disease, spinal tumours and spina bifida. Sometimes we must go even further afield to diffuse meningo-encephalitis. Not uncommonly the cause is a primary or secondary affection of the peripheral nerves. All nervous lesions may give rise to the same trophic disturbances—wounds, bruises, incised wounds, various compressions, all kinds of neuritis, whether infective or toxic, changes in nerves consequent upon varicose dilatations, and phlebitis of the intra-nervous veins and so on.

Still more, the ætiological factor in the production of perforating ulcer may be even more general, for it may be due to a constitutional infection such as leprosy, mercury or alcohol, to a diathesis such as diabetes or a general dystrophy such as arteriosclerosis. The lesion may occur elsewhere than on the sole and under aspect of the toes, and you must not be surprised to find it now and again on the palm, in the sacral region, over the coccyx, etc.

Let us now discuss the ætiological problem of perforating ulcer. It is only complicated in appearance and you will soon grasp the nature of the lesion. If we question the patient we find that at thirty-four he was under medical care for grave pulmonary congestion. Seventeen years ago he had a chancre with the usual sequelæ and he underwent several courses of mercurial treatment. His tongue testifies to past syphilitic manifestations, so that there can be no doubt of the syphilitic nature of the infection. He tells us without being questioned that at twenty-five he had short sharp pains in both legs which were put down to rheumatism—a very common error against which you should be on your guard. Having reached their maximum intensity these pains subsided in the course of a few years, a very troublesome sensation of girdle pain and thoracic constriction taking their place. These in their turn disappeared, and for some years all that he complained of has been of both lower limbs.

Pains of this kind, dating back some fourteen years, coming on in short, sharp crises, at once makes one think of commencing locomotor ataxy. But the knee jerks are present though dull, and even the ankle reflex, which is usually the first to disappear, can still be elicited, though not so active as normal, and less marked on the left side than on the right.

At first sight it would be hard to say that the patient is ataxic, he can turn round promptly and can walk up or down stairs, etc., without hesitation. Yet when he shuts his eyes there is some unsteadiness of gait, especially in starting and stopping, and he throws out the leg. He sways when standing up and cannot remain erect, *i.e.*, Romberg's sign.

There is no loss of muscular strength, yet his arms and legs are peculiarly flaccid and flexion movements are unduly ample, in short, there is hypotonus. Carrying our examination a step further we find that he has had some trouble in respect of micturition for months past. He is often obliged to wait awhile and to strain to set it going, sometimes, indeed, he is obliged to squat in order to empty the bladder. At other times there is a slight incontinence, not only of urine, but also of the fæces. Sexual desire is lessened, yet he has frequent nocturnal emissions. Testicular sensibility is lessened. All these symptoms are important in view of their grouping, but we now come to something much more significant, *viz.:* the results of examination of the eyes. There is no evidence of any mischief of the fundus, no disturbance of external movement (never any diplopia), but there is obvious inequality of the pupils and a diminution of the pupillary reflex to light.

These then are the principal symptoms and, as you have seen, it has been necessary to look for them pretty closely; this fact may explain how it is that his condition has escaped diagnosis for fourteen years or so.

Apart from the trophic symptoms which brought the patient to us I would lay special stress on four cardinal symptoms; the lightning pains, Romberg's sign, the urinary troubles, and the state of the internal muscles of the eye. Three of these symptoms occurring together would suffice to establish the diagnosis, and when we have the fourth it becomes a certainty. This man, although the disease has existed for fourteen years, is still in the præ-ataxic stage. This stage has been of long duration and it may last much longer. The special feature in this case is the tendency to perforating ulcers. This is a case of trophic tabes in which the nutrition of the lower limbs is very markedly modified. The joints of the foot share in these changes, one of them especially, the metacarpo-phalangeal joint of the left big toe, is much enlarged and grates on being flexed. Both feet are much flattened and this deformity, as you know, is often due to tabes, but it is only the outcome of trophic disturbances of the joints, allowing of relaxation of the ligaments and fibrous bands that normally maintain the arches of the foot. As a matter of fact I do not think that tabes need be invoked in the present instance for the deformity dates back to early life and he has been subjected to long standing and multiple fatigues. Moreover, he had, even young, a well-marked tendency to varicose veins. His father suffered from arterio-sclerosis, so that the conditions were such as to favour nutritive disturbances of the lower limbs. From its onset the disease found a ready-prepared soil and the early nerve troubles soon gave rise to trophic disturbances. Such cases are by no means rare, in fact, I would impress upon you that these trophic disturbances are not only a possible complication of confirmed tabes, but are often a very early, nay initial, symptom of the disease. You will see, therefore, that we must not concentrate our attention too exclusively on the state of the reflexes.

And now, in order to bring clearly before you the remarkable polymorphism of tabes. I will show you a third patient, a woman, æt. 33 years, without any interesting pathological antecedents. Married at fifteen, she was divorced, and re-married at twenty-eight. She only had one child, who died at two months of age. The confinement was followed by some obscure, probably infective, uterine trouble which did not pass off, and four years ago the adnexa were removed. Advantage was taken of the opportunity to remove the appendix because she suffered at the time from vomiting. The genital troubles subsided, but the vomiting persisted so that the appendix was evidently not to blame.

Six years ago, when æt. 27, she first noticed severe pains in the legs—a stabbing, radiating pain, "as quick as lightning" as she describes it. The pain recurred daily just before going to bed and prevented sleep. The attacks lasted about half an hour and then suddenly subsided. Here again, and I must insist upon the fact, the pain was diagnosed as rheumatic and treated as such. Then came on the vomiting, at first easy and bilious, it occurred at any hour of the day and had no obvious connection with meals or with the kind of food. Note that the vomiting was absolutely painless. For four years the vomiting recurred in crises, at variable intervals. Eighteen months ago (at 31) the attacks began to be accompanied by severe pain in the back, chest and epigastrium. Sometimes the pain was stabbing, like that of an ulcer, sometimes in the form of girdle pain, sometimes constrictive. The attacks often coincided with the periods, which is often the case in these visceral crises. At first the attack lasted two or three days, then a week, and recently a fortnight. While it lasts the patient avoids taking food and, curiously enough, does not seem to feel any the worse for the abstention, though of considerable duration; in short, she seems to have lost the sense of hunger. The painful attacks are often followed by diarrhœa. She lost flesh and became the subject of intense nervous depression. The only thing that did her any good was morphia, and she drifted into the morphia habit. I shall have occasion to point out, shortly, the part played by these injections in bringing about a repetition of the gastric troubles.

Moreover the pains in the lower limbs had never quite left her, indeed, they had also made their appearance in the upper limbs, especially on the internal, ulnar aspect, the thenar eminence and the little finger. For five years these various pains were the sole manifestations of the disease. But during the past year she noticed that unless she paid particular attention to her feet in walking she was apt to stumble and she found going upstairs very difficult. She is subject to a frequent desire to pass water without necessity, while at other times she is unable to retain it. On more than one occasion she has passed motions involuntarily.

So much for her history; you will already have made up your minds as to the diagnosis, but we will proceed to corroborate it. She tells us that she is unable to walk in the dark, and you have only to watch her trying to walk with her eyes shut to see how matters stand. The ankle reflexes are abolished, the knee-jerks are diminished, the pupils are unequal, the left (the larger) being quite insensible to light, while the right is sluggish. The pupillary reflexes, however, respond to accommodation; in short, she exhibits the Argyle-Robertson phenomenon.

Obviously it is a case of tabes. That is easy enough to say now, but was it equally so a few years ago? Every physician is aware of the fact that gastric troubles are among the symptoms of the præ-ataxic period, but what is perhaps less clearly recognised is that this symptom may usher in, and for a long time remain the sole and only feature of, the clinical picture. How many times have the gastric manifestations given rise to an erroneous diagnosis of gastric ulcer, or gastritis with pyloric stenosis or intermittent attacks of hepatic or nephritic colic? It is very easy to make this mistake, all the more so because it is customary to comprise all tabetic stomach troubles under the term "gastric crises." The student always looks for the picture of the grand tabetic crisis and loses sight of the diversity of form in which it may present itself. In this case it came on as painless vomiting, in another it may be gastralgia without vomiting, "stomach cramps"—there is only one feature in common, *e.g.*, their periodical evolution, their recurrence in attacks which become more and more frequent, often monthly, corresponding with the menstrual periods.

This case enables me to direct attention to a feature which was clearly defined some years ago by Roux in his thesis, *viz.*: the degree in which these attacks are influenced by anterior dyspepsia, by the nature of the food and by medicinal gastritis following the administration, by the mouth or subcutaneously, of sedative remedies. Under this double influence the characteristic features of the tabetic crisis—its suddenness of onset and subsidence—may be lost, so that the crisis is disfigured so to speak. I need hardly insist upon the disastrous effects of repeated injections of morphine on the stomach. The more frequent the injections the shorter is the interval between the attacks and the more severe are they. A large eater, an old-standing dyspeptic, this patient stood every chance of her tabes commencing by the stomach. Under the influence of her medicinal intoxication the attacks become more protracted. Nutrition was gravely interfered with and morphia no doubt had much to do with the intense nervous depression that followed.

Our first care then must be to demorphinise the patient reserving the drug for the severest attacks of pain. We must put her on milk diet for a few days and then a lacto-vegetarian diet.

The best means at our disposal to calm the pains and visceral manifestations is the injection of nitrite of soda. For ten days following inject one cc. daily of a 2 per cent. solution of the salt, then ten days rest, then two cc. daily followed by a period of repose, then ten days with three cc. daily, and so on until four cc. daily is being given. This treatment has yielded very satisfactory results, but not in every instance. In the event of failure we must not leave these unhappy patients to their fate, we may employ electricity, baths of ultra violet rays applied to the loins, &c.

AN outbreak of infectious disease has occurred in rural Essex. It is believed to have been caused by the introduction of London poor children on holidays. As many of the affected children as can be got into the isolation hospital there are being so treated, the remainder being kept at their country lodgings. Efforts are being made to ascertain the liability of the charity organisations which sent the children into Essex, and that of the children's parents, but it is much to be hoped that this unfortunate *contretemps* will not affect the good work of the children's holiday funds.

ORIGINAL PAPERS.

SOME OBSERVATIONS ON
THE USE OF CALCIUM SALTS.

By S. J. ROSS, M.D., Vict.

Surgeon, Out-Patients' Bedford and County Hospital.

I NEED only in passing, remind your readers of the debt of gratitude we owe to Professor Wright and Dr. Ringer for the pioneer work they have done with reference to the value of calcium salts as therapeutic agents.

My object in writing these notes is to draw the attention of busy general practitioners to the value of calcium salts in certain common and often troublesome conditions.

Childblains.—I have employed calcium chloride, gr. x., thrice daily and given in a tumblerful of water, in ten cases with complete success. The drug was given for two days, then omitted for three days, and administered again for two days. The average duration of treatment was fourteen days.

Ulcers of the Leg.—I have used calcium iodide, gr. iij., thrice daily in fourteen cases; combined with rest and low diet. In each case the drug was administered intermittently, and in each case the ulcer healed soundly and rapidly. Locally I employed Ung. Hydrarg Ammon. Seven of these cases were varicose ulcers. The ages of the patients ranged from 17 to 86 years. In one case the patient had remained in bed for two months but the ulcer refused to heal. After the commencement of the calcium iodide treatment the ulcer rapidly improved, and was soundly healed in three weeks. I have noticed that for the first few days of this treatment the ulcer discharges more freely than before this treatment was commenced.

Epistaxis.—I had a very severe case of epistaxis occurring in a patient, æt. 74 years, with markedly atheromatous vessels and high tension pulse. He was freely purged, sent to bed, and placed on milk diet. His left nostril, from which the bleeding took place, was plugged with a strip of cyanide gauze soaked in adrenalin solution. Hæmorrhage persisting, I gave the patient calcium chloride, gr. xv., twice; the hæmorrhage ceased and did not recur.

Painless Œdema of the Ankles.—A youth, æt. 20 years, complained of swelling of both ankles. His heart and urine were normal. I gave him gr. xv. of calcium chloride thrice daily for three days and the œdema cleared up. Two months after this he presented himself with the same condition, which yielded to similar treatment.

Tertiary Syphilis.—A man, æt. 47 years, had a syphilitic perforation of his hard palate. I gave him potassium iodide, but this he could not tolerate, symptoms of iodism quickly appearing, I then put him on calcium iodide, gr. iij., thrice daily. This he took without inconvenience and continuously for two months, at the end of which time the perforation had healed.

Menorrhagia.—A lady, æt. 30 years, who was subject to attacks of epistaxis and erythema nodosum had a very profuse period. She told me that her skin very readily bruised. I ordered gr. xv. of calcium chloride ter in die, and the hæmorrhage ceased. Nine months after this she had a similar attack checked by the same drug.

A case of Pneumonia with free hæmoptysis.—I had a case of pneumonia in a patient, æt. 45, a marked alcoholic. The left lung was solid. He expectorated blood freely. I gave him calcium iodide, gr. iij., thrice daily for three days and the hæmorrhage ceased. The patient ultimately recovered.

Remarks.—These few cases have impressed upon my mind the value of this drug in the conditions I have indicated. The only unpleasant symptom complained of in three cases was nausea, which was stopped by increasing the dilution of the drug. Syrup of orange in drachm doses renders the mixture more palatable than if it be given in water only. There are many other conditions in which calcium salts have been successfully employed, *e.g.*, rickets, hæmaturia, hæmatemesis, erysipelas, erythema nodosum, functional albuminuria, hæmophilia, in gall bladder operations where adhesions are anticipated and as a result free hæmorrhage (I can vouch for its value in these cases when given twenty-four hours before operation), and in the rashes following serum injection.

Calcium salts are said to raise the blood pressure. They certainly did not raise the blood pressure of the case of epistaxis I have cited. Had the blood pressure been raised to any appreciable extent the result would have proved disastrous.

I have personally been most impressed with the beneficial action of calcium salts in the cases I have cited. To those of your readers who have not tried them, I say try them. To those who have tried them let me ask them to add their experience to mine, as an ounce of experience is of more value than a pound of theory.

THE DEFINITION OF BLINDNESS IN CHILDREN: ITS CAUSES AND PREVENTION (*a*).

BY ADOLPH BRONNER, M.D.

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THE definition of blindness, as generally accepted, is that the vision of both eyes is so bad, that the patient cannot see well enough to find his way about in daytime, or count his fingers at twelve inches. Even adopting this very narrow point of view, we find that in 1901 there were no less than 25,317 blind people in England and Wales, or 771 to every million of the population. These figures are not very accurate, as there are a large number of blind persons who do not acknowledge that they are blind, and, on the other hand, a fair number who are blind, but whose vision could be improved by operation or treatment. Of children under fifteen years, 423 out of every million of that age are blind. But I think that in dealing with this very important question we should not only include the blind, but also all children who suffer from defective eyesight, certainly those who do not see well enough to read ordinary school books. If this were done, the numbers would be very much larger. And, surely, from a practical point of view, a child who cannot see to read is nearly as badly off as a child who is quite blind. I should suggest that some universal standard of defining the various degrees of weak-sight be adopted for all countries, so that our statistics may be of a uniform nature. Vision of 6/9 to 6/12 to be called "fair sight," 6/18 to 6/24 "weak sight," 6/36 to 1/60 "bad sight," and "less than 1/60" blind. It would then be easy to divide the children into different classes for teaching purposes. At present there are generally only two classes, for the normal-sighted and for the

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(*a*) **Read before the International Congress on School Hygiene, London, August, 1907.**

blind. There certainly ought to be at least one intermediate class for these children who are not blind, but can see a little. In time some of these could be drafted into the first class, and some into the third, or blind class.

Most cases of blindness in children are due to disease, about 80 per cent. Magnus examined 3,206 blind children and found that in 17 per cent. the blindness was congenital or due to malformation of the eyes, mostly hereditary or due to congenital syphilis; in 33 per cent. to diseases of the eyes, including 23.5 per cent. which were caused by purulent ophthalmia; in 8 per cent. to trauma; while in 33 per cent. it was the result of some general disease which had affected the eyes; in 7.5 per cent. to small-pox. Roughly speaking, 8–10 per cent. are due to congenital syphilis. Cases of trachoma, or granular lids, are very rare in this country. Harman could only find five cases in 70,000 English children. For many years, 1869 to 1900, contagious conjunctivitis was very prevalent in the Hanwell schools, and caused many cases of blindness. This was, however, stamped out by the untiring energy of Dr. Stephenson.

These statistics only include children who are quite blind, and no notice is taken of those with defective eyesight, or who are blind on one eye only. Thus, those cases of progressive short-sight, which are so often met with in school children, cases of ulceration and disease of the cornea, which are so very common and cause defective eyesight, and many others, are not included. There are 25,317 blind people in England, but how many are there with defective eyesight? At least half a million. Even to non-medical men, these figures are appalling, and one naturally asks, cannot something be done to prevent so many unfortunate people from becoming weak-sighted or blind?

Cohn and others have examined 1,000 blind people, and assert that in about 40 per cent. of these, the blindness could have been prevented. That means that there are more than 12,000 blind people in England today who need not be blind, but who should be able to see as well as you or I. And tens of thousands who are suffering from defective eyesight which could have been prevented.

1. CONGENITAL BLINDNESS.

Congenital blindness could, to a great extent, be avoided, if persons suffering from hereditary diseases of the eye, chiefly cataract, optic atrophy, and retinitis pigmentosa, were not allowed to marry. When both parents are born blind, often all the children and their offspring become blind. In Bradford there is a family of blind parents with five blind children, all of whom were in the workhouse. A large number of cases of congenital blindness are due to syphilis, and many cases of blindness which occur in early childhood are caused by the same disease. These could, to some extent, be avoided, if every case of syphilis were treated for two years, and not allowed to marry during that time. An American physician has recently advocated State regulation of marriage, through a Board of Guardians. He predicts that if this is not done, "Americans will in time be chiefly idiots and imbeciles."

2. INFANTILE PURULENT OPHTHALMIA.

Purulent ophthalmia of infants is a very common cause of blindness. No less than 23.5 per cent. of all cases of blindness in children, according to Magnus, are due to this disease, and 72 per cent. of all cases under one year of age. It is an inflammation of the inner part of the lids, characterised by a copious creamy discharge with swelling of the eyelids. It causes ulceration of the cornea (transparent front part of the eye), with consequent opacity, or perforation and complete loss of the eye. It is due to direct infection at the time of birth, or at the dirty hands of the midwife, and caused by a germ called the gonococcus of Neisser. Fortunately it is not as common as it used to be. Formerly 30 to 50 per cent. of all babies, at least in the lying-in hospitals, became affected, now only 0.25 to 0.1 per cent. Thanks to improved methods of treatment, purulent ophthalmia is not nearly so dangerous as it was some years ago, when 40 to 50 per cent. of all cases became blind. Now only about 4 per cent. lose their sight, and 15 to 18 per cent. have defective vision. The best methods of treatment are, as soon as the eye becomes red or there is the slightest discharge, to inject 2 per cent. nitrate of silver drops between the opened lids, three times a day, or, better still, 10 to 20 per cent. protargol or argyrol drops every one or two hours, or peroxide of hydrogen drops, or to insufflate airol powder, and, in some severe cases, to paint the everted lids with 10 per cent. nitrate of silver; also wash out the eyes with 1 in 3,000–5,000 perchloride of mercury lotion (warm), and with a glass irrigator, and not with a dirty sponge, as is so often done. It is very often difficult to get the drops and lotion between the lids, as these are very swollen, and it requires the help of a skilled nurse. All cases, therefore, which cannot be carefully treated at home, should be admitted into hospital at once. Most cases occur in the private practice of midwives. At last a Midwives Bill has been passed, and many of those dirty, disreputable old women who called themselves midwives have disappeared, let us hope for ever. According to the rules of the Central Midwives Board, "every midwife must decline to attend alone, and must advise that a registered medical practitioner be sent for, whenever there is inflammation to even the slightest degree of the eyes and eyelids." They, however, very frequently do not do so. Last year at the Bradford Royal Eye and Ear Hospital I saw no less than five cases of purulent ophthalmia, in which the midwife had treated the eyes for several days and not sent for a doctor. Three of these children are now hopelessly blind. The rule should be made much more stringent, and the midwife should be obliged to send for a doctor within twelve hours, and if she neglect to do so, should be most severely punished. In America, in some States at least, they are fined up to 100 dollars, and get up to six months' hard labour. Why cannot we do this in England?

The parents, especially the mother of the child, should be told of the great danger of this disease. Some years ago the Committee of the Bradford Royal Eye and Ear Hospital communicated with the Registrar-General, drawing his attention to the prevalence and danger of purulent ophthalmia, and suggesting that every registrar should be requested to give a printed card with instructions to every person who registered a birth.

"*Instructions Regarding New-Born Infants.*"

"If the child's eyelids become red and swollen, or begin to run with matter within a few days after birth, it is to be taken to a doctor immediately. The disease is very dangerous, and if not at once treated, may destroy the sight of *both* eyes."

The reply received was very characteristic. "A similar request has been made three years ago by the Ophthalmological Society, but it is impossible to adopt the suggestion, because the registrars are not salaried officers, but are paid by fees for the registration of each birth, and cannot be asked to undertake a duty, the distribution of such cards, unless they are offered some additional fee." Thanks to the kindness of the local registrar, such cards were for some years distributed in Bradford. Similar slips have also been issued by the Committee of the Gardner's Trust for the Blind, 53 Victoria Street, Westminster. I do not know of any Trust which fulfils its duties in such an efficient manner as this Trust. Mr. Wilson, the Secretary, is always pleased to give advice or help in any matter concerning the blind, and the prevention of blindness.

As the Registrar in Bradford is no longer willing to distribute these slips, the Committee of the Hospital send some to every midwife working in the district, and also cards with special directions. These are also distributed among the out-patients of the hospital.

3. DISEASES OF THE EYE.

A large number of cases of defective vision and blindness are due to disease of the cornea and other parts of the eye. Ulcers and inflammation of the cornea (which are very common in children), if neglected or not carefully treated, cause opacities, more or less marked. The longer the ulcer lasts and the more frequently it recurs the more dense will the opacity become, and the more defective the sight. Every case which cannot be properly attended to at home should be at once admitted into hospital. The same applies to disease of such delicate structures as the optic nerve and retina. These require most energetic and careful treatment, and, if neglected, cause permanent blindness. If all these cases which occur in the homes of the poor (where careful nursing is often impossible) were admitted into hospital, thousands of children would be saved from defective vision and blindness. Unfortunately, however, there is not enough accommodation in our hospitals. In the West Riding of Yorkshire, with about 3,000,000 inhabitants, there are not more than two hundred beds available for eye cases, and these are nearly all filled with operation cases. At the Bradford Royal Eye and Ear Hospital we have only forty-five beds, and draw patients from a large part of the West Riding. Last year 1,100 operations were performed, so that we had very few beds available for cases of disease.

4. SMALL-POX.

7.49 per cent. of the cases of blindness, according to Magnus, are due to small-pox. Before the days of vaccination 30 to 40 per cent. of all cases of blindness were caused by this awful disease. In 1901 no less than 980 cases of small-pox in children of five to thirteen years were recorded. Of the 230 children who had been vaccinated (some probably most inefficiently) only three died, whereas of the 750 who had not been vaccinated, no less than 141 died. In spite of these and many other equally convincing figures, we find that our wise Government is affording still further facilities for non-vaccination. Fanatics are allowed in and out of Parliament to abuse vaccination and incite stupid and ignorant parents not to have their children vaccinated.

5. EXAMINATION AND CARE OF THE EYES OF SCHOOL CHILDREN.

We now come to the important question of the examination of the eyes of school children. The State compels all children to attend school, and it is, therefore, clearly also the duty of the State to see that these schools are properly conducted, and that the children are in a fit condition to make use of them. All schools should be under medical supervision, and every child should be examined to see if it is fit to attend school. Bradford was one of the first to appoint a School Board medical officer, and Dr. Kerr was elected. Unfortunately for Bradford Dr. Kerr was soon called to London as the medical officer to the London School Board. I hope that everyone present, who takes an interest in school work, reads Dr. Kerr's annual reports to the Education Committee of the London County Council. They contain most valuable and interesting information on the medical aspect of our schools.

The vision of every child should be tested as soon as it can read large letters. This can be done by the teachers. Those whose vision is less than 6/9 should be examined by the medical officer, and a register kept of all cases. The parents should then be informed that the eyes of the child are defective, and asked to send it to a doctor, or, if the parents are poor, to a hospital. According to Dr. Kerr's statistics no less than 10 per cent. of the London school children have defective eyesight. The majority of these cases require glasses. If the parents neglect to send the children to a doctor or to provide glasses for them they should be compelled to do so. Dr. Kerr says that in London, "only the minority of these cases secure any further treatment." How different it is on the Continent! At Mannheim, of 250 children whose eyes were reported as defective, all, with the exception of nine, had been seen by a doctor within seven days. Many parents are too poor to buy glasses. These should be supplied by the local authorities. But they refuse to do this. The result is that hundreds of children attend our schools who cannot see well enough to profit by the teaching. In London a voluntary association has been formed, and they supply ordinary spectacles at 10d. a pair, about one-fourth to one-tenth of what is generally charged. It has always struck me as very absurd that medical men examine the eyes of the poor at the hospitals gratuitously, and that these patients often then fall into the hands of unscrupulous opticians, who make a larger profit on the glasses than the consultation fee of an ordinary medical man would have been. A large number of school children and others fall into the clutches of advertising quacks, who not only rob them of their money, but ruin their eyesight by supplying wrong glasses. In my opinion the best method of dealing with the children of the very poor would be, that they be examined at the schools by specially qualified medical men at the expense of the local authorities, who should also supply glasses free of charge when the parents cannot afford to pay for them.

All children with defective eyesight should be examined at least once a year, and a record of each case kept. This is specially important in cases of short sight, or myopia. Often the vision becomes rapidly worse, and special attention should be paid to these children, to see that they are supplied with proper glasses, and do not bend their heads when reading and writing. It is absolutely scandalous to see how the children sit at some of our schools when writing. They have their heads down, nearly touching the desk, often supported on a hand, and held sideways. The desks are frequently most unsuitable, and the light and ventilation most defective. Luckily myopia, especially the severe form, is not very common in England. At the Bradford Royal Eye and Ear Hospital last year, out of 6,000 patients, 1,720 were far-sighted and only 582 short-sighted, and very few of these were of the progressive type.

The points to which I should particularly have liked to draw attention in this very incomplete paper are :—

1. That in the statistics of blind children we should also include those with defective sight, certainly those who cannot see well enough to read ordinary school-books, and sub-divide these cases into the following classes :—

(*a*) Fair vision up to 6/12.
(*b*) Weak vision 6/18 to 6/24.
(*c*) Bad vision or nearly blind, 6/36 to 1/60.
(*d*) Blind, 1/60 and under.

That in all large schools special classes should be formed for children with defective vision, and that they should not be taught with the blind children.

2. All midwives should be obliged to notify every case of purulent ophthalmia to a doctor within twelve hours. Should she fail to do this, her licence should be withdrawn, and she be fined not less than five pounds.

3. The parents should be warned of the great danger of purulent ophthalmia, by means of pamphlets or cards, which should be given by the registrar to every person who registers the birth of the child. The midwives should also be supplied with similar cards.

5. Greater facilities should be afforded for the practical and theoretical teaching of ophthalmology at our medical schools, and practical and written examinations should be made compulsory.

6. Abolition of the conscience clause in the Vaccination Act. Punishment of all those who publish misleading statements on vaccination.

7. The eyes of all school children should be periodically examined by an expert. A record kept of all cases with defective vision, and these to be examined every year. Parents should be compelled to see that all such children are treated and supplied with glasses, if necessary. The poor children should be examined at the schools, and supplied with glasses free of charge.

8. Every case of reported blindness should be examined by a medical man, to see if nothing can be done to improve the vision.

9. People suffering from hereditary blindness should not be allowed to marry. No person who has had syphilis should marry for at least two years after he has contracted the disease.

CHRONIC SUPPURATIVE DISEASE OF THE MIDDLE EAR,

WITH SPECIAL REFERENCE TO SURGICAL TREATMENT.

By E. MALCOLM STOCKDALE, M.R.C.S.,

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JACOBSON, in the section dealing with surgical anatomy in Morris' *Treatise on Anatomy*, refers to otitis media as "this frequent and fatal disease;" and the statement of Wilde that "when a discharge from the ear exists we can never tell how, when, or where it will end, or to what it may lead," still expresses the prognosis. The discharge is a constant source of annoyance to the patient; and the time spent in attending for treatment over a long period, with the expense of drops, lotion, etc., may be a serious matter to the working-man, so that after a while he is likely to discontinue treatment, and run grave risks of developing dangerous complications.

In almost every case this disease has its origin in the mucous membrane of the nose or naso-pharynx, the pyogenic organisms extending to the tympanum along the Eustachian tube. They may be conveyed by the blood-vessels, the lymphatics, or may perhaps spread in the form of a superficial catarrhal inflammation. The result of this invasion is that the middle ear becomes a culture chamber for various bacteria, the micro-organisms most commonly present being streptococci, staphylococci, or pneumococci. These cause local pathological changes, varying in their nature and extent. The mucous membrane alone may be attacked, becoming hyperæmic, œdematous, and exuding a muco-purulent or purulent dischage, usually the latter. Later. polypi may form, or the mucous membrane become pulpy and thickened, or replaced by granulation tissue. The tympanic membrane may be destroyed, the ossicles shed, the labyrinth be invaded, and caries or necrosis of parts of the temporal bone may also occur. In certain cases the disease may remain localised to the tympanum, but in almost all, the mastoid antrum sooner or later becomes involved.

Again, the mastoid antrum may be seriously diseased, but the tympanum not damaged beyond recovery. Relating to the extent of the destructive changes produced, the virulence of the infection is often a more important factor than the duration of the suppuration. Cases developing during an attack of scarlet fever are frequently of a severe nature.

The type of case which I wish to discuss is that in which the chief symptoms are a purulent discharge of some duration from the external auditory meatus, with more or less impairment of hearing, and sometimes pain. In cases of this nature, are we to stand by until urgent symptoms or dangerous complications arise; or. finding conservative treatment of no effect, shall we interfere? I am convinced that when the charge persists in spite of antiseptic treatment carefully carried out (the nose and naso-pharynx having received attention if necessary), surgical interference is called for. We should not wait till the mucous membrane lining the tympanum or mastoid antrum is disintegrated, and perhaps the hearing destroyed.

When should operation be advised? The virulence of the infection and the nature of the lesion present are the factors in deciding this question, but a discharge lasting three months under conservative treatment usually calls for surgical assistance.

What form of surgical procedure should be employed?

Before a definite answer can be given, it is necessary to ascertain as far as possible the character of the pathological changes present. The following points should be investigated:—

(1) The condition of the tympanic membrane; (2) the presence or absence of the ossicles; (3) the presence or absence of granulations or (aural) polypi; (4) the amount and character of the discharge; (5) whether caries or necrosis exists. Since the character and position of the chief lesion varies, the nature of the operation required can only be decided after investigating the local condition. If the disease is localised to the tympanum, and can be dealt with efficiently through the external auditory meatus, there is no object in opening the mastoid antrum, nor should removal of the ossicles and drum membrane be undertaken if treatment of the antrum alone would lead to recovery.

The chief operative measures at our disposal may be considered under the following headings:—

(1) Intra-meatal, which are performed through the external auditory meatus.

(2) Post-aural, in which an incision is made behind the ear and the soft parts *drawn forwards*.

Intra-meatal Operations.—Aural polypi are best removed by means of a small snare, carrying a fine pliable wire. The loop should be passed over the polyp and gently manipulated towards the root of the pedicle, which should be cut through, as roughly tearing the growth away may cause serious damage, since it is impossible to predict its point of attachment.

Granulations projecting through a perforation in the tympanic membrane should be removed by means of a small aural curette, the field of operation being clearly illuminated, so that each movement of the curette is clearly observed and has a definite purpose. Removal of polypi or granulations will often arrest the discharge and effect a cure. The following case is of interest in this connection.

A man, æt. 29, had suffered from otorrhœa and deafness of the left ear for eight months. One evening he coughed and something was discharged from his ear, followed by hæmorrhage. He carried the specimen to his medical adviser (Dr. Holmes, Anfield), who informed him that it was a polypus. When I examined him six days later his ear was dry and the perforation in his tympanic membrane appeared to be healing. A fortnight later no perforation could be seen, and his hearing was greatly improved by inflation with the Eustachian catheter. He has apparently cured himself, having discharged his polyp by a forcible inflation through his Eustachian tube. Still operating through the meatus, ossiculectomy calls for notice.

Ossiculectomy.—Excision of the tympanic membrane, the malleus, incus, and perhaps the outer wall of the attic, with the removal of any granulation tissue, is of value in some cases, being a much less severe procedure than any post-aural operation, but its application appears to me to be limited, since in almost all cases of chronic suppurative otitis media the mastoid antrum is involved, and in many the ossicles have been previously lost, as a result of the suppurative process. My experience of this operation is limited to four cases. In those selected the discharge was small in amount, the tympanic membrane thickened, and the hearing greatly impaired. The discharge has been arrested in all, and in two the hearing is somewhat improved.

POST-AURAL OPERATIONS.

Heath's Operation.—In the *Lancet* of August 11th, 1906, under the title of "The Cure of Chronic Suppuration of the Middle Ear without removal of the Drum or Ossicles or Loss of Hearing," Mr. Charles Heath, of London, described an operation and published the result in ten cases. In all, the hearing power was improved. Briefly stated, the opening and final stages of this procedure are similar to the radical mastoid operation, the essential points of difference being that the tympanic membrane, ossicles, attic, and antro-tympanic passage are left intact. Details of the after-treatment are given.

The title of this paper might convey the impression that the removal of the ossicles and tympanic membrane results in loss of hearing. This, however, is not the case, excellent hearing being retained if the receptive mechanism is in sound condition. It has even been suggested that the ossicles and tympanic membrane are chiefly protective in function, the conduction of vibrations being of secondary importance. Heath's operation commends itself to me as valuable in those cases where the tympanum and antro-tympanic passage are not seriously disorganised, the chief seat of the suppuration being in the mastoid antrum. My experience of this operation is limited to two cases, as in most of those placed under my care the ossicles had already been lost, or the lining membrane was so diseased that the radical operation appeared necessary.

Case I.—R. R., boy, æt. 4 years; discharge from right ear three years; commenced during an attack of measles. Hearing? Heath's operation, November, 1906. Antrum found to be very large, and communicated with some superficial mastoid cells. The antro-mastoid cavity was filled with stringy pus. Last seen, March 1st, 1907. Soundly healed. Hearing good. Watch 12'.

Case II.—E. J., a girl, æt. 10, was admitted to the Liverpool Eye and Ear Infirmary on May 7th, 1906, with a history of suppuration in the right ear for two years; temperature 100°, and pulse 126. She had a cough, was emaciated, and looked very ill. After a week in the infirmary patient was discharged, as her condition suggested advanced phthisis. Eight months later the girl returned, being in better health, but still suffering from a profuse discharge and severe pain at times.

As no abnormal signs were now detected in her chest, Heath's operation was performed in January, 1907. When last seen her ear was soundly healed, and she could hear my watch readily at 20' in a somewhat noisy out-patient room, which is excellent hearing. I am inclined to think that the condition supposed to be phthisis was probably an attack of septic pneumonia secondary to the disease in the ear. Skin-grafting was not necessary in either case. I may perhaps here be permitted to mention that I have recently employed Heath's method in two cases for the treatment of acute suppurative disease of the mastoid cells and antrum, and think that the operation will be useful in these cases.

The Radical Mastoid Operation.—This operation is indicated when the disease is of an extensive and destructive nature leading to disorganisation of the mucous membrane lining the tympanum and mastoid antrum, or caries or necrosis in the deeper parts of the bone, and when other methods of treatment have failed. Subsequent skin-grafting by Thiersch's method, although not always necessary, is of the greatest value when the exposed granulating area of bone is extensive, as occurs when the mastoid antrum is large and its lining membrane destroyed, many months of troublesome after-treatment being avoided by its adoption. The grafts may be introduced through the post-aural wound or the enlarged meatus, according to circumstances. In the case of a boy who happened to be a bleeder, I used frog-skin with an excellent result. During the past two years it has fallen to my lot to perform the radical mastoid operation at the Liverpool Eye and Ear Infirmary on sixty occasions. In this consecutive series of operations two marked anatomical variations were met with. In one, the lateral sinus was very superficial and situated immediately behind the posterior wall of the meatus,—the bone in each position being less than ¼-inch in thickness, and the bony meatus small. In this case the difficulty in obtaining sufficient room to use even a small gouge was so great that I performed the whole operation with a small burr, driven by an electric motor. In the other, the mastoid antrum was absent, but below the Fallopian canal there was a deep recess, which has been termed by Mr. Ballance the fossa of the aqueduct. Attention was drawn to the importance of this fossa in a paper on the "Surgical Anatomy of the Temporal Bone," read at a meeting of this Society a few years ago by my friend and colleague Mr. Hugh E. Jones. On this patient I performed my thirty-seventh radical operation; and being unable to find the antrum in the ordinary way, introduced Stacke's protector into this fossa, thinking it to be the antro-tympanic passage, cut down upon it, and injured the facial nerve. I have since ceased to use this instrument.

Facial Paralysis.—The abnormal condition I have just described occurred in a man æt. 38 years of age. He had suffered from a purulent discharge from the left ear for nine years, with frequent severe attacks of pain which kept him awake at night. His discharge and pain have been cured and his hearing improved, but he has facial paralysis as a result of the operation. However, the fact that chronic suppurative disease of the middle ear often leads to paralysis of the facial nerve must not be overlooked, since in five patients it was present from this cause when they first applied for treatment, and one developed it as a result of the disease while under treatment. Of these six patients in whom the nerve was involved by the disease, one had recovered completely three months after the operation, and a recent case is steadily improving.

Two cases, when last seen, were *in statu quo* in one the greater part of the cochlea was removed as a sequestrum. The fifth case I mention occurred in a baby eight months old. It was first seen in November, 1906, and had suffered from a discharge from the left ear for seven months; this was profuse and very offensive.

Exploration revealed the fact that almost the whole of the mastoid and petrous portions of the temporal bone were necrosed. Removal of the dead bone brought into view an extensive surface of dura mater covered by unhealthy granulation tissue both in the middle and posterior fossæ. A considerable portion of the lateral sinus was exposed, and the internal carotid artery could be seen as it descended to enter the cranial cavity. I am afraid the prognosis here is not favourable as regards the nerve. In the sixth case the operation was only undertaken a week ago, so that it is too early to expect recovery.

In considering the risk of life from direct extension of the disease, I find that in five cases the lateral sinus was already laid bare, and septic phlebitis might have originated at any moment. For infection of the sinus to occur, however, it is not necessary that it should be directly bathed in pus, as septic organisms may extend to it along small veins in the bone. In another case the roof of the antrum was perforated, the aperture leading to a small extra-dural abscess in the middle fossa.

THE EFFECTS OF THE DISEASE AND OF THE RADICAL MASTOID OPERATION UPON THE HEARING.

In a large proportion of cases, chronic middle ear suppuration leads to a considerable degree of deafness. Two patients in this series were deaf and dumb as the result. I have previously mentioned the fact that the loss of the drum membrane, with the malleus and incus, does not necessarily cause deafness. On the other hand, removal of these may lead to a marked improvement in the hearing. My observations of the effect of the radical mastoid operation upon the hearing have been most encouraging. In a large majority the hearing has been improved by the operation, and in many cases to a marked extent. In only one case do I find a note that it was made worse, the extent being slight—a diminution of ½' as tested by my watch. Discharge thirty-eight years.

Does the operation lead to a complete and permanent arrest of the discharge; and if it fails in this respect, where is the seat of suppuration? I will admit that discharge may be met with after the radical operation, and proceed to enumerate the causes I have met with:—

(1) Faulty operation or faulty after-treatment; (2) Inflammatory exudation from the Eustachian tube; (3) Omission to skin-graft when the raw area is extensive; (4) Ulceration of weak cicatricial tissue.

Since the above can be prevented or treated, the final result should be a complete arrest of the discharge.

When the radical operation has been successfully performed and the after-treatment efficiently carried out, the patient derives the following advantages:—

(1) Freedom from the ever-present risk of dangerous complications, such as meningitis, pyæmia, or brain abscess; (2) Arrest of a troublesome and often offensive discharge; (3) Freedom from attacks of pain (which are common); (4) Freedom from the risk of involvement of the facial nerve; (5) and lastly, my investigations show usually a considerable improvement in the hearing; and where this does not ensue, I hope its further destruction is prevented. I am inclined to think that when suppurative inflammation of the middle ear has resisted conservative treatment, the risk in every respect of allowing the disease to run its course is much greater than the risk of even the complete post-aural or radical operation; and, further, that if all cases of suppurative otitis media were carefully treated from the onset, the number of cases requiring this operation would be considerably diminished.

ON PHYSIOLOGICAL SINS AND A HEALTH CONSCIENCE (a)

By J. C. McWALTER, M.A., M.D., D.P.H.,
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By a physiological sin we understand a breach of the laws of health, and by a "health conscience," we mean a habit of thought which induces us to obey the dictates of right reason on matters which concern the health of the community. The stern and awful voice of duty has hitherto only been listened to in the moral domain, and has been supposed to have no jurisdiction in purely physiological phenomena, but we now begin to see the imperative necessity of recognising the teachings of science as they point the means of elevating the physical well-being of a whole people. Because deflections from the laws of health invariably bring their own punishment there has been rather a tendency to sympathise with the offender as one from whom payment to the full would be exacted —as an unfortunate fleeing from a Nemesis sure to overtake him—as a debtor pursued by a merciless creditor certain to exact punishment. The opinion prevailing is that such a one has done what is foolish, rather than what is wrong, and is imprudent, but by no means evil. It now becomes necessary to make it realised that a physiological sin—an infraction of the law of health is not merely the unwisdom of the individual, but an outrage on the community—not simply a matter of individual interest, but an offence against the general well-being. As such it is an offence against society—an anti-social act—and must be punished either by municipal law or by the censure of every right-thinking person. It is obviously an important element in the training of the young that they should be taught to recognise not only what is morally, but what is physiologically wrong, and that they should be encouraged to develop a health conscience to warn them against offences in sanitary matters as well as an ethical sense.

Idleness may be an ethical sin, but it is a physiological sin to work when fatigued. Mental work uses up the energy of the nerve cells, and fatigue follows. "Fatigue in every shape," says Ribot, "is fatal to memory." The impressions received under such conditions are not fixed, and the reproduction of them is often impossible. When an organ is over-active, its nutrition suffers, and halts, and fatigue ensues. When the normal condition is restored memory comes back. Over two thousand years ago Plato taught that in mental matters the half might be greater than the whole. We now find that in elementary schools "half-timers" progress quite as much as those who attend full time. Chadwick insists that children from eight to ten should work only about three hours daily, and those from twelve to fifteen six hours. I submit that to make a child of twelve or fourteen years *submit* to six hours mental study daily is a physiological sin. It is far too much. Fatigue, as Beech points out, rapidly passes into exhaustion. There is soon loss of force, both physical and mental, and action is less easily excited through the senses. Irregular movements will occur, the fingers will twitch when the scholar holds the pen, and he becomes not only fidgety, but nervous and peevish. His eyebrows are corrugated and he is puffed under the eyes. He is slow in his movements, and in his physical activity. His face lengthens through relaxation of the muscles, sighing and yawning set in, his speech is slow and his voice weak. Plainly, it is a physiological sin to let such an individual work at his lessons. He must have fresh air, and sunlight and rest.

Scrofulous children, and those of consumptive parents are often apt to learn; they are quick, sharp, and clever. But it is a sin, in our sense of the word, to do so—they *must* be pushed back, not forced on. We are sometimes told by a medical pedant that there is no such thing as the "brain fever" which novelists and mothers speak of. This is mere playing with words, such children get meningitis and die of it, and the common prejudice which used to exist against forcing precocious children is only too well founded. Hundreds still die every year from premature mental strain. To deprive growing boys and girls of sufficient sleep is another physiological sin. It is greatly doubtful if a boy or girl can sleep too much; it is positively certain that thousands of unfortunate young people have died the victims of the "early to rise" proverb. Dr. Duke says that a boy of ten should get eleven hours daily sleep, and a boy or girl of thirteen years, ten hours. This rule I submit should be amended by adding that if they want more they should have it.

Again, it is a physiological sin to build a school, or to inhabit one, on a clay soil. It is wholly dangerous to children of a rheumatic, gouty, or consumptive tendency. A gravel soil should be selected when possible. I am wickedly tempted to think that it would be a good thing if a boy who for years has spent his days with mouth open, and his nights snoring, and who has been the victim of chronic headache and the butt of everybody for his stupidity, were to shoot his parents when he grows up and finds himself deaf and useless, and hears that he could have been cured if his mother had troubled to bring him to a surgeon to get his adenoids removed in time. Ideas of parental duty are being rapidly recast and fathers and mothers who are now inclined to deride us as faddists because we insist on medical inspection of schools and scholars will shortly be called on to render a terrible account to their offspring if they find themselves the victims of defects of vision, or hearing or health, or of deformity, which the parents could have had corrected if they had listened to our warning in time. Nothing is more certain than that in a few years children will demand satisfaction from their fathers for every evil or inconvenience from which they suffer, and which might have been averted by timely care.

Fifty years ago Herbert Spencer spoke with wonder chastened with admiration of a friend of his, a physiologist, who declared that his children should be taught nothing until they were eight years of age. We have during the half century tortured and killed hundreds of thousands of children by sending them to school at three and four and five years, and yet we insist on a still larger holocaust of victims before we will be convinced of the folly of our acts. Still, we have learned something from those hundred of thousands of victims, and it is now scarcely necessary to argue that it is a physiological sin to send a child of three or four, or five years to school; seven years ought to be the lowest limit, and up to that age the whole energy of the parents ought to be expended in making the child a healthy little animal. If it is ill-behaved all the better. It is simply wicked to punish the natural instincts of young children in order to make them behave.

It is a physiological sin to make boys and girls keep quiet unduly much. As motion is the only means of practising anything, it ought to be encouraged.

(a) Paper read before the International Congress of School Hygiene at London, August, 1907.

Motive action should be cultured and directed to definite ends. As children grow older ideal suggestions have more force so that the memory image of a movement is apt to produce the movement itself. Fletcher Beach shows that children can control the muscles of the limbs before those of the fingers, and it is cruelty to force a child to write before it attains control of the limb muscles. There is now less need than formerly to insist on the physiological wickedness of long hours of study; the mind like the body, can only assimilate at a certain rate, and if you drug it with facts faster than it can assimilate them they are soon rejected. Much of the honour for bringing about a clearer vision as to the folly of the older system of protracted study is due to Herbert Spencer, who so eloquently exposed the fallacy where he says:—

"Once more, the system is a mistake, as involving a false estimate of welfare in life. Even supposing it were a means to worldly success, instead of a means to worldly failure, yet, in the entailed ill-health, it would inflict a more than equivalent curse. What boots it to have attained wealth, if the wealth is accompanied by ceaseless ailments? What is the worth of distinction, if it has brought hypochondria with it? Surely no one needs telling that a good digestion, a bounding pulse, and high spirits, are elements of happiness which no external advantages can out-balance. Chronic bodily disorder casts a gloom over the brightest prospects, while the vivacity of strong health gilds even misfortune. We contend, then, that this over-education is vicious in every way—vicious, as giving knowledge that will soon be forgotten; vicious, as producing a disgust for knowledge; vicious, as neglecting that organisation of knowledge which is more important than its acquisition; vicious, as weakening or destroying that energy without which a trained intellect is useless; vicious, as entailing that ill-health for which even success would not compensate, and which make failure doubly bitter."

In avoiding one physiological sin we fall into another. So soon as it had been drilled into the dull head of the British parent that an excess of mental work was a mistake, that there was much to be said in favour of play—that all natural instincts, and all pleasure-giving instincts subserve a useful purpose—he proceeded with the zeal of a proselyte to go in for games in the schools, but instead of letting the lads have wholesome play he exorcised the greater part of its joy and benefit by converting exercise into a formal and rigid system of gymnastics. Happiness is the most powerful of tonics, and though in a measure gymnastics are good, and far better than study, for children, they lack that spontaneity and agreeable excitement which gives so much value to play. The riotous glee of children at their games cannot be re-placed by carefully graded gymnastics.

The feeling that girls should not indulge their sportive instincts as freely as boys is gradually dying out, but many prejudices against it still prevail. Nothing is so baseless as the view that games indulged in by the natural instinct of girls, and not forced upon them, tend to give rise to unladylike habits. On the contrary, experience proves that they lead to a more harmonious development of the female organism, and that the finest female characteristics follow the development. As Spencer finely says, whoever forbids girls the sportive exercises prompted by Nature forbids them the divinely-appointed means to physical development. One might go farther, and proclaim that it is a physiological sin to forbid a child anything which it wants to eat or drink. Instinct is a perfect guide in the lower animals—it is unerring in infants—it is always useful in invalids; it is seldom unsafe in adults leading an ordinary life, and why should we deem it bad for growing boys and girls? Our forefathers had a rough general rule that natural instincts were the results of some inherited vicious trait and ought to be checked or denied or extirpated. It was an article of faith that sugar was bad for children, that they should behave and keep quiet, and that the wisest man was he who kept children under the most severe control. Now we know that the desire of young people for sugar is most useful for their nutriment, that it is a blunder to obliterate natural instincts, and that excessive control is most injurious in its after effects, but we hesitate to proclaim the great truth of which these are particular instances—namely, that all the desires of children are good, and that none of them should be stamped out, but merely subjected to some control.

We are told on authority that the effects of casual repletion are less prejudicial, and more easily corrected than those of inanition, and that excess is the vice of adults rather than of the young, who are seldom epicures. The passion for meddlesome mis-government finds an outlet in the nursery when it can be effectually resisted elsewhere.

The laws of health must be recognised before they can be conformed to, and hence the imparting of a knowledge of the laws of health is a necessity for a more rational method of teaching and living. Full robust health is the surest pledge of happiness, and none can hope to enjoy it who have not some inkling of its rules. These have not been taught hitherto in the schools, those who have learnt them have picked up their information in various by-ways and corners apart from the orthodox sources. The time has come for the creation of a national health conscience for the universal recognition of the duty of every man not to injure his neighbour in health no more than in purse. If the functions of a health conscience were recognised we should not have one person insisting that the window of the tram or train be closed, lest he should get cold, whilst half a score of others are suffocated or diseased for want of fresh air. The Public Health Acts make it penal for persons who suffer from scarlatina or the like, to travel on public vehicles, but those who have influenza or consumption may be much more dangerous and these travel at will. Many travellers complain that the American laws against expectoration amount to a perfect tyranny, but unless the health conscience of our people protects them against indulging in this disgusting vice for the future, we must have as drastic laws for this country. Another plague which would be exterminated if the health conscience existed is that of ringworm and the allied skin diseases which are the bane of every school. Let a mother's children get ringworm or whooping cough, or measles, or any ailment reputed "catching," and she is perfectly indifferent if every other child in the town gets the same—in fact, she not only invariably blames the school, but she feels rather a grievance if the other school children escape the maladies. She will further exhibit the utmost ingenuity either to keep her affected children at school, or at least to send them back before they cease to be sources of danger to others. That a grave obligation exists in every family and on every individual not to propagate to others the disease from which they suffer is a truth which must be instilled into the mind whilst it is still young and impressionable. And finally, as there are physiological sins against individuals, those also commit a physiological sin against the State who fail to rear a healthy stalwart race to succeed them. To bring to the country's service a large and healthy family is not only to discharge our duties to posterity, but is a proof of clean living, and high thinking and fine ideals. Year after year the Registrar-General's returns bring irrefutable evidence of an almost widespread desire for this obligation to be shirked, and morally it is a pressing duty on every educational system to instruct each rising generation on the nobility of paying this debt.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Cholecystectomy.—Mr. Joseph Cunning operated on a woman, æt. 56, who had been admitted with the following history: For twenty years she had suffered from attacks of pain in the region of the gall bladder. Two of these attacks of pain many years ago were evidently typical biliary colic, but the later attacks of pain were of a different nature; that is to say she had attacks of pain, vomiting, and constipation, lasting for several days, which were evidently attacks of localised peritonitis. The last attack had laid her up for three weeks. Another point in the history was that she had never been jaundiced. Her symptoms since admission consisted only of tenderness on pressure in the neighbourhood of the gall bladder. Mr. Cunning, before operation, pointed out that the patient's present condition, together with her previous history was sufficient to diagnose the presence of a gallstone, without any history of attacks of biliary colic or of jaundice, for, if there was one large stone, there was no possibility of its getting into the cystic duct, and thus producing colic, or of its blocking the common duct and thus giving rise to jaundice; everyone nowadays admits, he said, that gall stones are a result of a catarrhal infective inflammation of the mucous membrane of the gall bladder, the presence of a stone in the gall bladder having pathologically the same effect as a concretion in the appendix, that is to say, the stone produces ulceration of the mucous membrane, so allowing bacterial invasion of the walls of the gall bladder and attacks of localised peritonitis, which may be either adhesive or suppurative, just as is the case when there is a concretion in the appendix. Further, even if there are multiple stones in the gall bladder and the cystic duct is narrowed or obliterated, there need be neither colic or jaundice; but if there had been definite attacks of pain and rigidity in the neighbourhood of the gall bladder associated with vomiting and constipation clearly indicating localised peritonitis, the surgeon was bound to recognise the presence of gall stones. The abdomen was opened through the right rectus by an incision six inches in length; the gall bladder was at once seen to be densely adherent to the liver, omentum and transverse colon. Packing was put in to protect the rest of the abdominal cavity, and the adhesions were with difficulty separated. During this process a fistulous communication between the fundus of the gall bladder and the transverse colon was exposed, and separated from the gut by excising a portion of the intestinal wall and stitching up the opening. Deeper down between the gall bladder and the duodenum the cheesy remains of an old abscess cavity were discovered. The peritoneum on the sides of the gall bladder was now incised and reflected so that with the finger the gall bladder could be stripped from the liver. The cystic duct was next isolated, clamped in two places and divided, and the gall bladder now being free was removed; the stump of the cystic duct was then ligatured. A drainage tube was then passed down to the site of the duct in case any leakage should occur and gauze was packed round it. The abdominal wall was stitched up in three layers, leaving just sufficient room for the tube and the gauze to project at the upper end. Mr. Cunning remarked that it might have been seen that a pillow was placed under the lower part of the thorax before the commencement of the operation to throw the upper part of the abdomen forward; he considered this an important point in the technique of gall bladder surgery, for it brings the parts concerned in the operation so much better into view. Another point in the technique of the operation, he said, was not demonstrable in this case, that is rotation of the liver: if the right lobe of the liver is grasped and pulled up through the wound, so as to rotate the liver on its attachments, the gall bladder and the cystic ducts are brought prominently into view; in this case there were so many adhesions about the right lobe that rotation was impossible. He preferred cholecystectomy to drainage of the gall bladder as the operation of choice when there was no blockage of the common duct, for it removes a diseased structure, and so prevents the possibility of the further formation of stones and the possibility of a fistula remaining after drainage. Again, it was not safe to drain a shrunken gall bladder, owing to the difficulty of bringing it near the external wound. The circumstances, he thought, under which the surgeon would prefer drainage to cholecystectomy were: if he had unskilled assistants, or if the patient were very fat; here the depth of the wound is so great that it is safer to drain rather than to excise the gall bladder. On opening the gall bladder which had been removed from the patient just operated upon, its walls were seen to be a quarter of an inch thick, the cystic duct was obliterated and there was one large single stone which was facetted. The explanation of the facetting and the singleness of the stone was accounted for by the presence of the fistulous communication between the gall bladder and the colon clearly showing that one or more gall-stones had escaped by that route; the one found in the gall bladder being about the size of a walnut had evidently been unable to escape into the colon. A little bile leaked from the wound during the first two days; this probably came from the raw surface of the liver, from which the gall bladder had been detached. Ten days after the operation the wound was soundly healed, and the patient going on well.

TRANSACTIONS OF SOCIETIES.

NEW SYDENHAM SOCIETY.

FORTY-EIGHTH GENERAL MEETING, HELD IN EXETER ON THURSDAY, AUGUST 1ST, 1907.

Dr. OSLER in the Chair.

THE report and balance-sheet for 1906 were presented. The report concluded with a recommendation from the Council that the Society should not be continued beyond the end of the current year.

In response to a request from the CHAIRMAN, Mr. HUTCHINSON said that, though he had himself written the report adopted by the Council, he was not wholly in accord with the recommendation that the Society should wind up its affairs. There were still nearly 900 members, and his sympathies went with the proposal that the Society should continue its work with certain modifications. He would propose to publish every year a volume of clinical lectures, short monographs or papers, translated from foreign sources, as promptly as possible after their original issue. The work of abstract-making which the Society's Year-Book used to accomplish was now exceedingly well done in the medical journals, but not a few of the papers with which medical literature now teems were well worthy of reproduction in full, and a valuable and attractive annual volume might be thus constructed. Secondly, he would like to see the Atlas continued, but with plates reduced in size and with less letter-press. It should copy nothing and produce only original illustrations of new subjects. It might suitably treat the subjects comprised in the volume of translated monographs. It might also undertake to reproduce selected drawings from among those exhibited at the annual meeting of the British Medical Association, and for this it might venture to ask for a subsidy. It might also come to an arrangement with the Royal Society of Medicine to publish some of the plates accompanying papers read before the Society, thus giving them a wider circulation and at the same time enriching the Atlas. It might be worth a thought whether a remodelled Society might not become more international in character, and enter into close relations with all English-speaking communities. He much hoped that the Society would not be given up, but that it should be remodelled somewhat on the above lines.

Dr. LEON proposed that a circular be sent round to the members, in which they should be asked whether they were in favour of the recommendation made by the Council that the Society should not be continued beyond the end of the current year, or of carrying on the Society on the lines suggested by Mr. Hutchinson. This was seconded by Fleet-Surgeon **Bassett**, and carried unanimously.

Dr. **Baildon** then urged that, in view of the importance of this step, it would be well that a statement of the outstanding liabilities and of all the assets of the Society should accompany the circular. This was seconded by Dr. **Gibson**, and carried.

Dr. **Coombes** proposed that the statement should be made by a chartered accountant. This was seconded by Dr. **Gibson**, and carried.

Mr. **Power** pointed out that many subscribers were more than satisfied with the atlas, and that some had paid for several years in advance.

Dr. **Russell** drew attention to the fact that the income of the Society had steadily diminished for several years past. There was unfortunately no indication of any recovery, as a large number of resignations had been received this year. At the present moment the Society was solvent, and if no further diminution in its members occurred, it could just be carried on, but with any further shrinkage a deficit would have to be faced, or its output would have to be diminished.

The meeting terminated with the usual vote of thanks.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 1st, 1907.

Abortion.

It is not always easy to make a correct diagnosis of abortion, certain circumstances, more or less frequent during the first two months, where the existence of pregnancy cannot be affirmed, may present themselves, and the question arises as to whether the case is really one of miscarriage or due to some other cause producing the symptoms observed. The diagnosis becomes thus very difficult, as no certain sign of gestation is observed, nor the usual symptoms generally accompanying the accident.

It is frequently thus with women who menstruate irregularly, or who become pregnant during the period of nursing, and who cannot reckon on the cessation of the menses. Sometimes also, local examination is rendered very difficult by the presence of subcutaneous abdominal adipose tissue.

In abortion the hæmorrhage, say Lepage and Ribemont, generally precedes the uterine contraction; the os presents certain modifications, it is patent, softened, and the clots are abundant. In dysmenorrhœa the pains precede the flux, the os is closed, the uterus is small.

In cases of fibroma complicated with metritis the diagnosis is almost impossible, at least for some time.

The question, has abortion taken place, appears simple enough at first sight, but it is not always easy to solve it, and even frequently impossible.

In the third or fourth month an error is impossible if the fœtus can be obtained; but in the first weeks the ovum is so small that it passes unperceived in a large number of cases. The majority of women believe simply in a more or less turbulent return of the menses which had been retarded. On the other hand it frequently happens that before the doctor has arrived, everything has been thrown away; clots and membranes, or the patient, seized with an imperious need to go to the lavatory, allows the whole mass to escape without paying much attention. The difficulty is still further increased from the fact of the death of the fœtus and its more or less prolonged retention in the uterine cavity.

Even when the physician has the parts under his eyes, it is often difficult to pronounce during the five or six weeks of gestation on account of the small volume of the ovum. The clots and different débris should be carefully examined under a stream of water and, where possible, the microscope should be employed, especially where the question is one appertaining to medical jurisprudence.

It is not always easy either to know if the abortion is complete, for the reason already given, but the general retention of the whole or of a part of the placenta may be inferred where the hæmorrhage persists when the uterus remains voluminous, and a priori when the finger can feel a portion of the placenta in the interior of the uterus.

The four great causes of abortion are:—Criminal manœuvres, syphilis, albuminuria, and vicious insertion of the placenta. Criminal abortion is difficult to determine and as admission is not easily obtained it can be only suspected. When it is of syphilitic origin the fœtus is expelled dead and macerated. If albuminuria is the cause the placenta presents hæmorrhagic spots and the urine contains albumen, there are signs of nephritis. In case of vicious insertion of the placenta recurrent hæmorrhage is observed, and the examination of the membranes will reveal the insertion on the inferior segment. The prophylatic treatment of threatened abortion needs no comment: rest in bed, opium by the mouth or by the rectum, viburnum prunis folium, ten drops of the tincture five times a day.

Where the miscarriage is unavoidable, where the hæmorrhage persists, the contractions continue, or the membranes are broken, or the fœtus is dead, the case should be treated as an ordinary confinement—disinfection of the external organs, antiseptic injections, and an antiseptic compress over the vulva and events awaited. Several complications are adherent to cases of miscarriages.

At first the hæmorrhage may be so intense that the life of the patient is threatened. If the ovum is intact and uterus closed the vagina may be plugged with antiseptic gauze for eight or ten hours. This plug excites by its presence the uterine contractions, and it is not rare to find behind it, when withdrawn, the ovum or the fœtus, the placenta being retained.

The ovum may be infected, although it may be intact, and here the plug can be used in provoking contraction. But if no result is obtained at the end of some hours, the patient should be chloroformed, the vagina disinfected, the os gently dilated and the uterus evacuated by digital curettage and abdominal expression.

Abundant and repeated hæmorrhage after expulsion of the fœtus may be also treated by the plug, but it is frequently badly done and inefficacious, allowing the hæmorrhage to continue behind it, retaining the clots and favouring infection.

To obviate this inconvenience, Auvard recommends intra-uterine plugging, which can render service in cases of extreme urgence, or where the patient is so weak that she is unable to support a curettage. Otherwise this method should be rejected as it might be the cause of accidents; digital curettage is much preferable, it suppresses the hæmorrhage by emptying the uterus and affords complete security.

Where the placenta is partially detached, or has fallen into the vagina, one is tempted to extract it either with the fingers or with a forceps, pulling at it with the hope of taking it out. Such a practice is reprehensible unless the operation is fully completed. Otherwise the placenta is broken and the hæmorrhage continues to endanger the life of the patient.

Frequently the placenta is retained after the fœtus is expelled with no other complications, neither hæmorrhage nor infection. Under such circumstances, expectancy is the rule. In the majority of cases, at the end of some hours the contractions recommence and the placenta is expelled.

The limits of this expectancy are difficult to determine; the placenta can remain several weeks in the uterus without provoking any infection and is finally expelled. In any case if it is decided to await events, the patient must be subjected to constant surveillance, the temperature taken morning and evening, vaginal antiseptic injections ordered, and everything held in readiness for artificial delivery in case of infection.

Even in cases where there is neither fever nor hæmorrhage prudence commands that the placenta should not be left in the uterus more than four or five days. The two methods employed for extracting the organ are instrumental and digital curettage. Each of them has its partisans and adversaries. Some prefer the curette during the first two months because the uterus is not much developed, the walls are sufficiently resisting, that there is no danger of perforation, that it is easier to penetrate the uterus without dilating the os, and that properly handled the instrument is cleaner and more easily disinfected than the finger.

Others reproach the curette with working in the dark, that it runs the risk of perforating the uterus, that it does not inform the operator on the complete and perfect cleaning out of the cavity in which débris of the placenta might be left.

The majority of surgeons of to-day reject the curette, among whom may be cited Pinard, Budin, Lepage. Every time that digital curettage is possible it should have the preference. If, as is customary with some surgeons, the curettage is done an hour, or two after the expulsion of the fœtus, no previous dilatation with Hegar's instruments is necessary. One or two fingers are passed into the uterus and the placenta extracted

Antiseptic irrigation follows to remove any small pieces, and finally the uterus is swabbed out with tincture of iodine or glycerine and creasote (1–5). After another antiseptic injection of the vagina a plug of iodoform gauze is passed into the uterus to ensure drainage. This plug is removed after twelve hours, and the intra-uterine injections repeated.

GERMANY.

Berlin. Sept. 1st, 1907.

AT the Hofeland Society, Hr. Westenhoeffer gave an address on

THE PRACTICAL SIGNIFICANCE OF THE THROAT AFFECTION IN CEREBRO-SPINAL MENINGITIS.

He said it was now generally recognised that in cerebro-spinal meningitis the tonsillar affection was the primary one. It was maintained by Hr. Goeppert, Kattowitz, that the whole respiratory tract was the point of entrance for the meningitis. This disease might easily escape observation, as the inflammation was seated in the upper part, hidden by the velum palati and was not on the tonsils. The cause of the primary localization lay in the lymphatic apparatus. The majority of the children attacked were such lymphatic characters. From this the rule should be drawn that the throat should be examined in all suspicious cases. Cases of meningitis were originated from the nasal passages, but not by the meningococcus. but by pneumococci and streptococci. On the other hand tuberculous meningitis did not set up a similar disease in the nares.

The attempt had been made to eliminate the disease from these parts by means of all kinds of gargles and washes for the nose and fauces, but without success. Meningococci seated in the mucous membranes were very resistant. Even removal of the tonsils had not been followed by any good results. Attention had very properly been drawn to the fact that a large bleeding wound only made more room for the bacteria to enter.

It was remarkable that the throat affection disappeared very quickly. It was present in the first days of the disease only and then showed intense redness and œdematous swelling.

The throat affection was, however, the cause of the extension of the disease. The germs must enter with the air respired and settle on the first suitable spot. The further spread occurred through expectorant material. As, however, children did not expectorate the schools were never the carriers of the infection. Although epidemic meningitis was exceptionally a children's epidemic, 90 per cent. of those who suffered from the disease being children, the spread took place through adults affected with the disease who expectorated the disease germs. All the people of industrial or colliery districts had a tendency to spit more than others, the possibility of the spread of the disease was, therefore, so much the greater amongst them.

There might be cases in which there was no throat affection. What, from a sanitary point of view, should be our attitude in respect of such cases, as such patients did not expectorate? The speaker related the case of a young man who had had his lumbar spine cocainized on account of an operation for piles who in some unexplained way developed cerebro-spinal meningitis. The throat was intact.

The epidemiological significance of the naso-pharyngeal affection lay in the fact that in all the cases the meningococcus could be found in the naso-pharyngeal space and the disease carriers determined. The infection passed along the nerve tracts, especially that of the trigeminus, and from here deep into the muscles of the pharynx. The disease gradually lost itself towards the periphery. Suppuration very rapidly attacked the muscles of the eye and the ciliary ganglion. As a rule, at least, there was no homogeneous infection of the brain. Before anything was seen in the meninges suppuration was seen round the arteries. The epidemics differed fundamentally; exactly as the clinical course might be, the anatomico-pathological appearances might differ just as much.

In the face of this disease treatment was powerless. Lumbar puncture was useful in some cases in others not. It only mitigated the symptoms. The same applied to other methods of treatment but in a higher degree. There were cases in which recovery took place during the first week. The cases are then as well as before, but a great number died during the first week and of the general intoxication. The remaining group was divided into those that recovered but with grave lesions of the nervous organs, especially those of sense, and those that died later. For these varied courses varied methods of treatment must be adopted.

Meningococcus serum had been recommended in the acute stage. Some favoured, others rejected it. The views were also most varied as to whether it should be used subcutaneously, or by the rectum, or spinal canal. Injections into the canal of the cord were the most deserving of confidence. The mortality, independent of treatment, was varied. In the Upper Silesian epidemic the mortality was from 50 to 70 per cent., in that then on it was 44 per cent. The injection of serum certainly did no harm.

When the disease had advanced into the second stage that of pyocephalus surgery was more in place than the injection of serum.

The speaker then showed how by trepanning at two spots the suppuration at the descending cornu could be drained. He had suggested methods of performing the operation and it had already been put into practise with success.

AUSTRIA.

Vienna, Sept. 1st, 1907.

LIPOID BACTERICIDE.

LANDSTEINER and Ehrlich have now completed their experiments with fatty material and give the following report: "We have carefully examined fatty hæmolytic substance in the form of organic extracts and found in every one of the experiments a positive result as a bactericide. We have found the extracts powerful toxines, for bacillus anthracis, vulgaris Bayeri, etc., as well as the fatty acids obtained from these extracts in the form of an emulsion. If this fatty acid be presented along with serum and then warmed it becomes inactive as bacterio—or hæmolytic—serum, but if this fatty acid is prepared in an aqueous solution and warmed in the same manner the bactericidal property is still retained and the results positive.

In the same manner we examined tissues with virulent Milzbrand bacilli after having treated them with the lipoid extracts and found them powerfully resisting the bacilli and therefore protective.

These experiments were carried on in the blood of animals with the same results in the leucocytes and medullary substance of bones.

We have also observed that Towel's bone marrow in a physiological solution of salt with the serum of the animal has a decided bactericidal action. This effect also disappears on gently warming the æther and serum mixture, but is retained if the component fluids be warmed separately.

They conclude with an assumption that bactericidal properties of the marrow of bones will yet play an active part in the treatment of germ disease or the intracellular bacteriolysis of the body.

Congenital Cerebral Motor Defects.

At the present time we have a large number of dreamers. The motor power of the brain only requires to be aroused to impart activity to the human organism, but very few apply themselves to investigating the real cause of this defect before commencing this resuscitating stimulant. We hear of many being born tired and unfit to continue the struggle for existence. Some attribute this primary agenesia to a congenital inhibition of the central ganglia of the brain, like Heubner, Delille, etc., while Möbius is inclined to accuse the nerve trunks which are often damaged by toxic agents that produce an enfeeblement of the nerve centres with consequent dystasia and agenesia of the muscular system. Neurath, in his anatomical research on the subject, has now concluded that both theories may be correct, and probably the one is the complement of the other. The loss of function may be developed in the trunk as well as the centre and both may be the result of a toxine. Neurath thinks that many of the cases the dystasia is in the muscular system itself, making a third source of production in the developmental inhibition. He is in doubt, however, whether the defect is in the centre, trunk or muscular apparatus.

Hereditary Squint.

Licherer records an interesting case of squint with ocular disturbance, handed down through several generations. The family seems to have been affected with strabismus during at least four generations; the first and second having large families, in whom the males, nine in number, had all strabismus convergens in the left eye. Strange to say, the children of those affected had also strabismus convergens in the left side with the additional ocular disturbance of hyperopia and amblyopia, while all the females were emmetropic and had no squint. The boys throughout these families confirmed Douder's assertion that strabismus convergens is somewhat closely associated with hyperopia and reduction of acuity of vision. The eldest son of the first family had three children, of whom the female was emmetropic, while the boys were emmetropic in the right and hyperopic in the left.

Cerebral Fatty Embolus with Tetanus.

The patient was healthy, but after a slight injury died. The clinical observation convinced Schmidt that the symptoms were the result of a fatty embolus. These signs were great disturbance in the circulation, with other changes in the motor phenomena that were inexplicable from tetanus alone. This was proved by many of the symptoms being relieved by removing the compression and providing collateral circulation, which improved the mental condition of the patient. The wound and its secretions were carefully examined for tetanus bacilli, but all in vain, though animal vaccination gave positive results. He concluded that the tetanus bacilli played a very small part in the toxic condition of the patient.

HUNGARY.

Budapest, Sept. 1st, 1907.

Gross Negligence of Two Forensic Doctors.

In Szeged, a large country town in Hungary (seven months ago), a railway servant took a girl to a hotel, where she, after enjoying herself fairly well with the servant, suddenly died. The girl was carried to the morgue, where two forensic doctors performed the *post-mortem* examination. Seeing a stabbed wound under the left eyelid of the corpse, they stated that the girl—who, by the way, was pregnant, being about in the eighth month—was killed; likely a pleasure-murder had been committed on her. On account of this statement of the doctors the servant was sentenced to seven years' imprisonment.

About two weeks ago the case was brought before the highest Court of Justice, the so-called Royal Curia, where the documents were given to Dr. Minich, member of the Board of Justicial Medical Advisors. He read the report of the two Szegedian forensic doctors, and spoke of the seriousness of such a fatal error as had been committed by them. He argued that "the man, who had been found guilty of committing murder, was innocent, because the cause of death could not have been the alleged stabbing wound under the eye. We know that even enucleation of the eye bulb does not give rise to such fatal bleedings as to cause death. (The forensic doctors alleged that the arteries of the bulb got retracted in the skull, and caused a hæmorrhage there, resulting in the death of the girl.) On the contrary, the apertures through which the arteries leave the skull, are so tight that the vessels cannot get retracted there. Besides, they are not such large vessels that a patient could die on account of their bleeding. We know that pregnant women, especially those nearing to the end of gestation, may get apoplexy in consequence of the bursting of a cerebral or meningeal vessel."

According to this opinion of Dr. Minich the Court ordered the exhumation of the corpse; this was done on the 17th of this month. The *post-mortem* examination has been performed by Dr. Genersich, professor of pathologcal anatomy. He found the bony eye hole intact, so that an injury of the brain at the time of the alleged stabbing could be excluded. He opined that death had been due to an apoplexy. As for the injury under the left eye, he expressed his suspicion that it must have been done after the death of the girl. This supposition was now born out by the confession of two witnesses, who carried the corpse from the hotel to the morgue. The men alleged that they had not seen any injured spot on the cadaver when they transported it from the hotel to the Morgue.

Dr. Genersich thinks that the wound arose either from rat-bite or was made by the throwing of the body hither and thither during transport.

The innocent railway servant was set free immediately after the declaration of Professor Genersich.

French Doctors in Budapest.

Twenty-six French doctors, all members of the Œuvre d'enseignement médical complémentaire, came on the 16th of August to visit Budapest and its medical institutions. Although the clinics were closed — being vacation — several notable professors left their summer residence and came back to Budapest to receive the guests in their own clinic. Lectures were held on different subjects, especially on surgical matters, and dinners and banquets were given in abundance during the three days stay of the illustrious guests.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

Death of Dr. Henry Murney, J.P.—One of the oldest, if not the oldest, member of the medical profession in Ulster passed away last week in the person of Dr. Henry Murney, who had attained the good old age of 83. His death was rendered rather pathetic by the fact that his sister, five years older than himself, who lived with him, and to whom he was deeply attached, died only a few hours before him. It was no doubt partly owing to this shock of her death that the end came suddenly to him. Dr. Murney was born in Belfast in 1824, and entered practice in 1849. In 1854 he was elected to the staff of the General Hospital, now the Royal Victoria Hospital, and for many years was an active member of it, and honorary secretary to it. He joined the Ulster Medical Society in 1847, and was president in 1871. He retired from active practice about 1884, and went to live at Holywood in Co. Down, where he lived the remainder of his life. Dr. Murney was a broad-minded Catholic Liberal, and a favourite with all classes and creeds. At one time he was a prominent member of the Masonic body, and a Justice of Peace for both town and county.

LETTERS TO THE EDITOR.

MILK AND TUBERCULOSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is quite evident that "A Family Doctor" regards bacteriological experiment in the laboratory as of more value than clinical observation.

I do deny that it has been demonstrated that tuberculosis has ever been communicated to the human subject by means of the tubercle *bacillus* conveyed in milk. I again ask for a single case.

"A Family Doctor" says, "the *possible* sources of infection in the case of the cow have been demonstrated by Dr. Armstrong." But I ask for the *actual* sources; for it passes my limited comprehension how a possible source of infection can be demonstrated. If it be demonstrated it is no longer a *possible* but an *actual* source. To say that a thing is possible cannot lead to any conclusion.

I repeat that "A Family Doctor" accepts statements unsupported by *evidence*.

It is only within a few years that the doctrine of the infectivity of phthisis has taken hold of the professional mind. Yet when this question was investigated at the Brompton Hospital for consumption not a single case could be discovered in which a servant or nurse had become infected.

The improvement that has taken place in the incidence of this disease throughout the country has been independent of the application of so-called modern science towards its ousting.

I have already shown that the *want* of milk plays a far more important part in the production of this disease in the young than so-called infected milk.

As it appears to be a hopeless task to wean "A Family Doctor" from his views in favour of bacteriological experiment as against clinical observation I shall not trouble you further.

I am, Sir, yours truly,
August 31st, 1907. GEO. GRANVILLE BANTOCK.

SANITARY ADMINISTRATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The *Times*, of August 26th, publishes a summary of Local Government Board Reports on the sanitary condition of numerous Lancashire boroughs and urban districts. The reports form a terrible indictment of the various authorities. In every district, Acts of Parliament, upon which the health of the people depend, and which it is the duty of the authority faithfully to administer are neglected or even completely ignored. In most places medical officers and sanitary inspectors are either not appointed, or are engaged and paid to give only a small and insufficient part of their time to their duties. Councils are often wilfully negligent, or, lacking the advice of skilled and experienced officers, remain ignorant of the requirements of modern sanitation, and unenlightened as to the nature and importance of the trust which the Legislature has placed in their hands. In many instances members of the authority seem evidently bent upon preventing the administration of laws in conflict with their private interests. The state of local government in the areas now reported on closely resembles that in other parts of the country which you have allowed me on previous occasions to criticise. In most of such places public opinion does not exist; recommendations of the Local Government Board, such as are made in the present reports, are disregarded, and vast masses of the people throughout the land are thus allowed to exist under conditions which give rise to great preventable mortality with corresponding injury to the physique of the nation. By far the greater part of the injury falls upon the poor. The impossibility of getting milk of fairly good quality for their infants in the many places where the adulteration Acts are not enforced, forms alone a terrible hardship for poor mothers. It would be easy to paint a picture of misery arising almost solely from bad government sufficient almost to justify the wild and revolutionary demands of the socialists whose fanaticism is very often roused and kept up by contemplation of the undeserved sufferings of the poor, to which society seems so callous and indifferent. The only cure for these evils lies in the rousing of the spirit of the nation. We ought to be all socialists, in the proper sense of the word, nowadays. If all that is respectable and intelligent among every class of the community will not take its proper share in the working of our democratic institutions these will fail and national ruin in the end will result. Certainly the fanatical socialism of the day will not save us, for that presupposes before everything a high level of altruism, to which only the smallest minority of any class of the people have attained. In the meantime, and pending the evolution of a higher level of citizenship, the position of the medical officer of health will remain in too many places as at present—ill-paid, precarious, and in every moral and material sense, unsatisfactory.

I am, Sir, yours truly,
Lancashire. August 28th, 1907. M. O. H.

SOUTHEND AND ITS MEDICAL OFFICER OF HEALTH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I venture to draw your attention to the recent action of the Southend Council in relation to its Medical Officership of Health. As a health resort, it is clearly a matter of vital importance to the town to preserve its sanitary standards at the highest possible pitch of excellence. Moreover, there are special reasons, owing to the shell-fish industry and the pollution of the foreshore with sewage, why the sanitary supervision of the place should be one of ceaseless vigilance. It seems hardly credible that under such circumstances the local authorities should have resolved to cut down the salary of their medical officership. Yet such has been the case and I understand that the present able holder of the post has very properly refused to accept a reduced and inadequate salary. The incident has a much wider significance than the mere unwisdom of the local Council of a small but hitherto popular watering-place. It presents the type *par excellence* of the penny-wise-pound-foolish policy that has left most of our watering-places hopelessly out of the race against their Continental rivals. Yet many of our British sea-side resorts are of unrivalled beauty—it is the sordidness of the private and municipal accommodation and the lack of first-rate recreations and public organisation that repels.

I am, Sir, yours truly,
London, Sept. 3rd, 1907. DAVID WALSH.

OBITUARY.

DR. JOHN WILLIAMS, OF CARNARVON.

WE regret to announce the death of Dr. John Williams, Carnarvon. The deceased, who was seventy years of age, was a native of Anglesey. He came to Carnarvon as assistant to the late Dr. Watkin Roberts many years ago, and subsequently joined that gentleman as partner, and remained in partnership till Dr. Roberts's death in 1897. Dr. Williams had been in practice for forty-five years. He was appointed medical officer of Carnarvon Goal in 1887, and was also medical officer for several local friendly societies. He became a member of the town council in 1874. In 1883 he was elected mayor, and during his mayoralty the beautiful Carnarvon Park was opened by the late Mr. Assheton-Smith. In politics the deceased gentleman was a moderate Liberal, and was a Churchman. He married Miss Gregson, of Kirkby Stephen, by whom he had three sons.

ANDREW GRAY, M.A., M.D.Edin., D.P.H.Vict.

We regret to announce that on August 30th the death took place at St. Helens, of Dr. Andrew Gray, one of the leading medical practitioners of the town. On August 25th Dr. Gray was cycling along Corporation Street, when another cyclist came up behind, and in passing came in contact with his wheel. Both men were thrown off their machines, and Dr. Gray sustained a fractured skull. The other cyclist, who apparently escaped unhurt, rode off, and has not yet been identified. Deceased was the son of Mr. Gray, of Dalkeith, a member of the Midlothian banking firm, and who acted as chairman for Mr. Gladstone. Dr. Gray, who was 43 years of age, studied at Edinburgh, and went to St. Helens eighteen years ago, having graduated M.B., C.M. in 1888.

SPECIAL ARTICLE.

A KENT PRACTICE SINCE 1690, WITH A LETTER ON "HE-SHE THINGS."

By GEO. H. BROCKLEHURST, B.Sc.

The village of Elham—which gives its name to the verdure-clad valley between Canterbury and Shorncliffe, which latter Wolfe, whom every schoolboy loves, selected for a military camp—was, up to the close of Century XVIII., a town of considerable importance in Kent. Hasted, in his history of the county, states that: "Elham is said to be the largest parish in the eastern part, extending from north to south, through the Nailbourn valley about three and a half miles, and from north-west to south-east five and a half." He further tells us: "The town is healthy and pleasant; the houses in it being mostly modern and well-built of brick and sashed." That the windows could be let up and down by pulleys, shows how up-to-date the town was in 1793; whilst its relative importance may be judged by its contribution to the county rate being £4 7s. 6d.; that of Sittingbourne being eighteen pence less, and that of Ashford only a guinea and sixpence more.

John Somner—named after his uncle, on his father's side, who offered to give a new Market House to the City of Canterbury on condition that the Corporation would make the market a free one—whose brother William was the vicar of the neighbouring parish of Lyminge, died after being in practice at Elham but a few years. A stone at the extreme east-end of the chancel of the Parish Church states: "Here lyes ye body of John Somner, Gent., son of the learned Mr. William Somner, of Canterbury, who dyed June the 7th, 1695, in ye 29 yeare of his age." Which William Somner was the antiquary, author of, amongst other works, "Antiquities of Canterbury," "A Treatise on Gavelkind," and "Roman Ports and Forts in Kent," published in 1693, which is prefaced by a life of Somner by White Kennett, afterwards Bishop of Peterborough, who states that "John practises Chirurgery with good repute," and that his mother became a "mourning Relict" for the second time, having married "Henry Hannington, Vicar of Elham."

The practice had passed into the hands of *William Pettit*, surgeon, by 1700, who died, aged 61, on April 30, 1739. Then into those of one, whose name is not known, though amongst his fees in the year 1747 are the following:—"Cook; bleeding 1s., two histerick draughes 2s., and a nervous tincture 2s." The next entry, lets "the cat out of the bag." "Cook" is not a surname; but the all-important "officer of health" of a well-ordered household. As the three next entries are "Mr.; the cure of his leg 5s., a cooling mixture 2s. 6d., and a rhubarb bolus 1s. 6d., possibly there had been a little over-eating. A good idea of a "bolus" and of the dress of this period may be obtained from H. Taylor's drawing, "A Country Doctor giving a Bolus to a Patient," engraved and published by J. Cary at the corner of Arundel Street and the Strand, Westminster, on March 25th, 1786," where a lady patient looks inquiringly, if not suspiciously, at the bolus—about three times the size of her thumb-nail, she holds between her thumb and index finger; whilst her medical adviser, whose head is well covered with a bewitching wig and a broad-brimmed soft felt hat, bracing up her courage evidently with "Now then, my dear lady, down with it."

When the "Blacksmith" called the doctor in he was given "a Cathartic 1s. and ointment 6d.; on the following day another Cathartic 1s.; two days after, a third Cathartic 1s, and more ointment 6d.," whilst on the fifth day he had "Phisick 1s.," bringing up his bill to a crown. Probably his wife, for the record states, "Wife of Blacksmith" fell ill just before Christmas—which it will be remembered was kept in March at that date—possibly from over-work preparing for that "family gathering," rightly held in such high esteem by those whose love can extend to each and every member. She was well in three days; the items of her account being: A mixture, on the first, 2s. 6d.; a Cathartic, on the next, 1s.; and a Bottle of Drops, on the last, 1s.

Then followed *James Miller Church*, surgeon, of whom little can be said with certainty, beyond that he evidently was a very common-sensed man. One of his favourite prescriptions was, "Keep the clay cottage of which you are the freeholder for life clean," adding, "then there will not be much wrong with you." Probably he was a son of Samuel Church of Sandwich, who died there on November 18th, 1793, aged 83; and of Elizabeth, his wife, who was buried at Elham on August 21st, 1796, aged 85. If so, doubtless his widowed mother passed her latter days under his roof. As there is no other record in the parish registers under this name, probably he removed to Sittingbourne; as there was a surgeon of this name in that town early in Century XIX. During his last years in Elham, he had as partner, who succeeded him, *Charles Rootes*," surgeon, apothecary and man-midwife," who appears to have been the son of a Nonconformist Minister of York, who died on June 8th, 1755. If so, he was fatherless at the age of 14, and had the advantage of the up-hill work of making his own way in the world—the best to bring out the best in a noble lad. He was in practice in the town by 1778, which was probably the year he came to Elham. He was liberal-minded large-hearted, and, as he had studied midwifery, evidently abreast if not in advance of his day, as the following shortened letter, addressed to the Editor of the *Sunday Reformer*—not the only Sunday paper of that day, by any means—shows.

"When apothecaries' apprentices are out of their time, they come to London to attend Anatomical Lectures, but instead of studying the whole of the human structure, together with practical surgery, they immediately turn their attention to that which is by no means proper for boys and young men—I mean midwifery. . . . The present race of males are become so effeminate, as to make it their chief practice . . . and write 'Surgeon and MAN-MIDWIFE' over their doors, and are well employed among the ladies. In short, Sir. I am persuaded, if something is not done to put done those multitude of HE-SHE things among us, called MEN-MIDWIFES, MEN-MILLINERS, MEN-STAY-MAKERS, MEN-MANTUAMAKERS, MALE-LADIES' HAIR-DRESSERS, yea, and WASHER-MEN also, who have started up like mushrooms of late; I say, if something be not done to stop this confounding of sex, like the language at the building of Babel, we shall ere long have a race of MALE Ladies' garter-tiers, Ladies' bathers, and I know not what . . . and scarce a truly masculine man, or a real modest woman, will be found.

"Pray, good sir, think of some remedy for this national evil; and, in the application of it you shall not want the assistance of—

"Your obedient Servant,
"Cadwallader Evans."

That the town should have one of these "He-She Things" is another proof of its importance.

Mr. Rootes was a bachelor till September 20th, 1779, when he took to wife by licence—then the "genteel" mode—in the parish Church, Mary Butcher, without doubt a popular and pretty "Elamite," as the late Canon Robert C. Jenkins, M.A., the widely-known, courtly, scholarly gentleman—well-known amongst his intimate friends as the "Abbot of Lyminge"—used to call the inhabitants of this parish.

In April, 1782, their son, William, was baptised, and two years later another, named after his father. Then followed four more—George in 1786, James in '90, Thomas in '92, and Richard born on December 8th, and baptised on December 24th, 1794, his godfather being Stephen Prebble, blacksmith, son of the above "Blacksmith," and William Noble, mine host of the "Rose and Crown," both exceptional men, his godmother being the wife of the former. Then came Mary, the flower nipped in the bud, their only daughter, who, as an infant, was laid to rest in God's Acre in 1797. There was one other son, baptised Edward in 1799, and possibly another John. With such a family Mr. Rootes showed his prudence by being a member of the "Benevolent Society for the Relief of Widows and Orphans of Medical Men in Kent," founded in 1787, by the usual payment of "twenty guineas, being in good health." His family was one of the 25 per cent of the families of members, whose circumstances necessitated the assistance of the society; and it speaks well for the generosity of the members that, during its first twenty years, thirty families had to do the same. Mr. Rootes lived to the age of 62, and was buried on February 7th, 1803.

Then followed *Thomas Noble Elwyn, M.R.C.S.*, whose brother, George, became Clerk to the Justices of the Elham Division of Kent about 1808, and who served the office of Under-Sheriff of Canterbury in 1811. The former year was the one in which Thomas, joined the above Benevolent Society for Medical Men; whilst the latter marked two important changes in his career. First he left Elham for Sandwich to carry on the practice of Robert Curling; then, in November, he journeyed—and it was a journey at that day, at that time of the year; but was he alone?—from that ancient port to Bath, where on the 16th of that month he married, "Elizabeth, eldest daughter of Sam Harvey, brewer of Sandwich, and niece of the late Vice-Admiral Sir Henry Harvey, K.B."

Then came Doctor Peck (or was it Thomas A. Pack?) of whom nothing can be gathered from documents; though he is distinctly remembered by that venerable inhabitant, Mrs. Court—better known locally as "Nurse Court," as having assisted the profession for many years—who attained her ninety-eighth birthday on February 24th last; and who, with a merry twinkle in her eye, is proud of never having been out of Court—though "I have been married"—from her cradle to the present day—her husband being her cousin Stephen; and who saw the Duke of Wellington on his landing at Dover from the Battle of Waterloo.

The practice then passed to *William Pittock*, who took his M.R.C.S.Eng. on May 7th, 1813, and then practised in Maidstone till 1831, when he removed to Elham. Here he practiced for over twenty years, being assisted first by his son, Francis William, who took his M.R.C.S.Eng., on May 4th, 1838, from that time till 1843, when he settled at Sellinge, in Kent; then by William Taylor Tyson—fourth son of Joseph Taylor Tyson, of Canterbury—who became a M.R.C.S. Eng., in September, 1834, and a L.S.A. the following year. In 1845, *Doctor Tyson* married Miss Regden, of Etching Hill, Lyminge; and two years later removed to Church Street, Folkestone, then the fashionable part of that town; rightly judging it would further his interests; and was at once elected Surgeon to the Folkestone Dispensary, now represented by the Victoria Hospital, of which his second son, Joseph Wm. Tyson, F.R.C.P., is one of the Hon. Physicians.

The Elham practice then passed into the hands of *James Beattie*, who took his L.R.C.S.Edin. in 1840, and M.R.C.S.Eng. fourteen years later. He was medical officer of Elham Union and surgeon to the East Kent Mounted Rifles. Dying in 1859, he was succeeded by *Hubert Beadles*, who received his medical training at Westminster Hospital, qualifying M.R.C.S.Eng., in 1857, and taking the L.M., and L.S.A. the following year. Then followed *William Bishop*, a native of Chipping Norton, Oxfordshire, a popular student at University College Hospital; who not only devoted himself to his work within the hospital, but was a devotee in defence of the profession; being the ringleader of that gallant little band, which set out one evening from the hospital to whitewash a certain lion, erected as an advertisement of a patent pill. The work was all but completed when "a gentleman in blue" appearing, the valiant, remembering that "discretion is the better part of valour," took to their heels, soon increasing the distance between them and their pursuer, who doubtless, having partaken of a good supper provided by a kind-hearted cook at the expense of her master, soon gave up the chase. In 1868, he qualified M.R.C.S.Eng., and three years later took the L.S.A.Lond., and L.R.C.P.Edin. Having gained some valuable practical experience as Assistant Surgeon of Sirhowy Iron Works in Wales, he settled in Elham, and shortly after married the sister of the present Lord Mayor of London. Besides holding the various local medical appointments, he was a member of the Royal Commission on Horse Breeding, and Hon. Secretary of the East Kent Foxhounds for over twenty years. He was a keen and true sportsman, loving all nature; his fellow-man, the robin and the wren, which he always greeted as "God's Cock and Hen," to the mushroom, which at one time he cultivated to such perfection that he obtained a shilling a pound in Covent Garden for them. The respect with which he was held by peer and poor was shown when his body was laid by the side of his friend, the late Walker Wodehouse, M.A., the beloved vicar of the parish, who for over half a century had "neither changed, nor wished to change, his place." The practice, traced for some two hundred and twenty years, is now in the able hands of Gordon H. Hackney, who also received his medical training at University College Hospital, qualifying M.R.C.S.Eng., and L.R.C.P.Lond. in 1901.

MEDICAL NEWS IN BRIEF.

A Vegetarian Manifesto.

The present season of discontent is usually made glorious in autumn by the sea serpent, the giant gooseberry, and "pater familias." It is still further enriched this year by the appearance of the following *naif* document which is forming a splendid "fill-up" for sterile news-sheets.

Medical Manifesto on Vegetarianism.

We, the undersigned medical men, having carefully considered the subject of vegetarianism in its scientific aspects and having put its principles to the practical test of experience, hereby record our emphatic opinion that not only is the practise based on a truly scientific foundation, but that it is conducive to the best physical conditions of human life. The diet of vegetarianism provides all the constituents necessary to the building up of the human body, and those constituents as proved not by the misleading tests of the chemical and physical laboratory, but by the experience of numerous persons living under normal conditions are at least as digestible and as assimilable as the corresponding substances obtained from flesh. We, therefore, claim vegetarianism to be scientifically a sound and satisfactory system of dietetics. Moreover, considering the liability of cattle and other animals to ailments and diseases of various kinds, and the pure character of food obtained from vegetarian sources, we are convinced that abstinence from flesh food is not only more conducive to health, but from an æsthetic point of view is incomparably superior.

Robert Bell, M.D., George Black, M.B.Edin., A. J. H. Crespi, M.R.C.S., H. H. S. Dorman, M.D., Albert Gresswell, M.A., M.D., Walter R. Hadwen, M.D., L.R.C.P., M.R.C.S., J. Stenson Hooker, M.D., Augustus Johnstone, M.B., M.R.C.S., H. Valentine Knaggs, M.R.C.S., L.R.C.P., Alfred Bolsen., M.D., Robert H. Perks, M.D., F.R.C.S., John Reid, M.B., C.M., George B. Walters, M.D.

It is a great thing to belong to a free, catholic, and tolerant profession!

Medical Man Shot by Patient.

Chapeltown, one of the fashionable suburbs of Leeds, was startled on Saturday morning by the news that one of its best known medical practitioners had been murdered by a patient.

Dr. Walter Clapham Hirst had among his patients a man named John William Harrison, aged about 40, who had recently become well known in the district owing to his eccentric habits. On Friday night last he visited Dr. Hirst's consulting room, and was then very strange in his manner, but after an hour's talk with the doctor he became quieter and left. Nothing more was heard of him until yesterday morning, when he again proceeded to the doctor's residence. He reached the house about six o'clock and Dr. Hirst appeared at the door in answer to the night bell. As soon as he opened the door Harrison remarked: "You are Dr. Hirst," and produced a revolver and fired twice at the doctor, who fell on the doorstep.

The sound of firing roused Mrs. Hirst and some neighbours, but before assistance came Harrison had turned the weapon on himself, and, firing into his mouth, fell by the doctor's body, his head being completely shattered. Mrs. Hirst found her husband still alive, but he was mortally wounded, for one of the bullets had struck him under the left side of the breastbone, another penetrating the chest a little lower down on the right side.

It is clear that Harrison's mind was affected. In a letter received by a friend Harrison said:—

"I was suffering terrific, and doctor struck me on both knees, which brings on epileptic fits. It was murder to me. He has killed me. I was all right before, but now am lost. The pains and fits are terrific. He has killed me wilfully and deserves punishment. He deliberately struck me on both knee-caps last Monday. It was murder. Farewell, old friend. No more happy hours in your garden."

Harrison added: "I have given the motive of the crime to Mr. ——."

A pathetic feature of the tragedy is that Dr. Hirst was married about six weeks ago to Miss Nellie Oldroyd, the daughter of a manufacturer. The bridal couple only returned a week ago from their honeymoon tour in Switzerland. Dr. Hirst, who was 28 years of age, belonged to Dewsbury. He was an M.B. of London, and an old student of Leeds and St. Bartholomew's.

Death Under Chloroform.

An inquest was held at Bredbury Hospital, last week, on the body of Emily Riding, three years old, operated on for double club-foot.

Dr. Thomas Birch, resident medical officer, said the operation was successfully performed, and the child was a fit subject for the administration of chloroform. The next morning, however, she showed symptoms of chloroform poisoning. She became unconscious, and died the same evening from cardiac failure produced by the delayed action of chloroform. The witness added that the child was not given very much chloroform, and the quantity had nothing to do with the fatal result. Dr. Birch added that he made a *post-mortem* examination which confirmed his conclusion. The deputy-coroner, Mr. Birch, pointed out that he had not given permission for a *post-mortem* examination to be made. He also mentioned that the child died on Thursday, and he only got information of its death Sunday morning. He did not think that the doctor was justified in giving his certificate in a case which was not death from natural causes, and, as might have been expected, the registrar refused the certificate.

The doctor explained that he was under the impression that in a case of that kind he was authorised to make a *post-mortem*, and that his evidence would not be complete without it.

The jury returned a verdict in accordance with the doctor's evidence in regard to the cause of death.

Death Under Ether.

Mr. Walter Schröder conducted an inquest on the 27th inst. at St. Pancras, on Kate Hartshorn, aged thirty-two.

The deceased underwent a slight surgical operation at the Royal Free Hospital for cancer, of the breast on the 17th inst., after which she was sent home in a cab. Subsequently it was discovered that a more drastic operation was necessary, and she was re-admitted to undergo this.

Dr. Charlotte Alice King, house-surgeon at the hospital, stated that on the deceased's re-admission the operation was deferred until the following Friday. It occupied two hours and a half, and during two hours ether was being administered. Mr. Cunning, one of the visiting surgeons, performed the operation. Signs of cardiac failure were observed, and the administration was discontinued, recourse being had to stimulants. Ultimately she expired, and, from the autopsy witness made, she concluded that death was due to cardiac failure, consequent on the shock of the operation.

Dr. Florence Elizabeth Willie, senior anæsthetist, said that the inhaler held nearly five ounces of ether. If she had a similar case she should, perhaps, have recourse to a stimulating infusion earlier during so prolonged an operation. Witness had administered anæsthetics in at least a thousand instances.

The jury returned a verdict of death by misadventure.

Inquest on Malvern Medical Man.

An inquest was held at Malvern, on August 23rd, by the District Coroner into the circumstances attending the death of Dr. Edmund Antrobus, of Great Malvern, who died after taking an injection of a sleeping draught. Mr. Guy Antrobus, brother of the deceased, who was sleeping in the same room at the time, said he heard Dr. Antrobus moving by the dressing-table. He got out of bed to see what was the matter. Deceased stumbled. Witness got him into bed and sent for doctors, whose efforts were, however, unavailing, death occurring within about an hour and a half. Deceased had been seriously ill from blood poisoning, contracted two years ago, but had seemed better lately. Evidence was given that at a *post-mortem* examination it was found that an exceptionally large dose of a narcotic containing opium had been taken, and that this was the cause of death. Several pricks, such as might be caused by a hypodermic syringe, were found. The jury found that the deceased had died from an overdose of narcotic, self-administered, to produce sleep. They expressed sympathy with the relatives.

Society for the Study of Inebriety.

The Second Norman Kerr Memorial Lecture, held under the direction of the Society for the Study of Inebriety, will be delivered by Robert Welsh Branthwaite, Esq., M.D., H.M. Inspector under the Inebriates' Acts, on Tuesday, October 8, at 8.30 p.m., in the Hall of the Royal Society of Medicine, 20 Hanover Square, London. The subject of the lecture will be "Inebriety—Its Causation and Control."

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Vaccine Treatment and Opsonic Control.—A series of papers of great importance appears in the June-July number of the *Johns Hopkins Hospital Bulletin.* Taken together they seem to place in fresh perspective the practical relation of opsonic control to vaccine treatment. I.—Cole and Meakins relate their experience of twenty cases of gonorrhœal arthritis treated by vaccines, and state their general conclusions arising therefrom. They deprecate the publication of the histories of isolated cases in which the writer has undertaken the treatment with great enthusiasm, and it is as a contribution towards wider statistics than are yet available that they publish their examination of a small group of cases of one disease. In their technique they followed with slight modifications the methods of Wright. The initial dose of dead gonococci was usually three hundred million, and the amount was gradually increased until a dose of one thousand million cocci was administered. No ill-effects were encountered, though a slight local reaction of pain, tenderness and redness always occurred twelve to twenty-four hours after the first dose. General constitutional disturbances following the injections were very rare. The general course of the opsonic charts is similar to that observed by Wright and his collaborators, but the writers did not find the "negative phase" at all marked. The ill-effects of a "negative phase" were not observed clinically, and a cumulative "negative phase" was never observed. The notes of the cases treated would seem to justify a stronger conclusion than the very moderate statement of the writers that their "impression is that the vaccine treatment as carried out, has been of distinct value." As regards the value of opsonic control, the writers point out that "considering the present almost certain inaccuracy of opsonic technique, and the absence of sufficient evidence as to the *rôle* of opsonics in immunity, it hardly seems advisable that the control of the administration of vaccines by the estimation of the opsonic index should be persisted in. We do not feel," they go on, "that the danger of cumulative negative phases is a real one. In no case have we seen the administration of gonococcus vaccine do harm, and we feel that these cases offer sufficient justification for the treatment of gonorrhœal arthritis by means of vaccines in doses of 500 to 1,000 million, administered every seven to ten days."

II.—Jeans and Sellards deal with tuberculin treatment and opsonic control. In technique they have made some important advances. Instead of grinding the dead bacilli in an agate mortar as recommended by Wright, they emulsify the living bacilli by rubbing them up in salt solution with a heavy platinum wire or a small glass rod. The emulsion is then sterilised by exposure to direct sunlight for ten hours. In the preparation of the smears they are fixed with methyl alcohol for thirty seconds, and stained with carbol-Fuchsin for one to two hours at 37° C., recolouring with 95 per cent. alcohol for three to four minutes, and counterstaining with saturated aqueous methylene blue for five to ten minutes. The writers note very great variations in the counts obtained from the same preparations and some from the same slides, and they regard the limits of error as much wider than has been hitherto supposed. Thus, by dividing a slide into three sections by transverse lines it was found that the section at the end of the smear contained 282 bacteria, the middle section 107, and the first section 140 bacteria in 50 leucocytes. In other cases they got from the same serum indices varying from 0.4 to 2.34. They think, therefore, that it is probable that large differences in indices mean differences in opsonic control, but they do not believe that small differences can be held to have any signification. As regards diagnosis, they have employed the opsonic method in a considerable number of cases without obtaining satisfactory results. They append the clinical notes and opsonic charts of nine cases of tuberculosis treated by vaccines, which justify their statement that the results obtained by the administration of T. R. tuberculin in small, infrequent doses as Wright advises, have given encouraging results.

III.—Wass reports certain theoretical studies in opsonics. In the first place he attempts to decide whether it is possible to raise the opsonic power of the serum beyond the very low limits with which Wright has, for therapeutic purposes, contented himself. The method employed consisted in repeated progressive inoculation :—(1) intravenously with dead staphylococci; (2) subcutaneously with living staphylococci; (3) subcutaneously with dead staphylococci. The animals employed were rabbits. It is not necessary to describe in detail the experiments which led to the conclusion that no high degree of opsonic immunity such as is possible in antitoxic and bactericidal immunity can be produced in rabbits by ordinary inoculation procedures with *staphylococcus aureus.* He next discusses the trustworthiness of Wright's method of estimating the opsonic variations. He shows by many examples the variations between different estimations of the same serum, and the variations shown even by normal serum. Thus, in the case of one normal human serum, thirteen observations showed variations between the limits of 0.52 and 1.95, and of another between 0.42 and 1.66. He is therefore led to conclude that *none of the present methods of estimating the opsonic control of the blood seem sufficiently accurate to be of practical value.* He suggests "that further efforts should be expended in finding a reliable technique for clinical purposes rather than in continuing to pile up statistics which are so inaccurate as to be misleading."

IV.—Klein discusses the subject of opsonics in typhoid immunity, and he shows that the opsonic index, as determined by Wright's method, bears no relation to the degree of immunity present, at any rate in the higher grades of immunity. The index seems to rise with the development of immunity, but with the further development it drops. He suggests as an explanation of this fact that the ambaceptor-laden bacteria are much more quickly digested by the leucocytes, and therefore rapidly become invisible.

V.—Russell discusses the specificity of opsonics and concludes :—(1) Following injections of bacterial vaccines, the increase of opsonics is probably due to the formation of immune opsonics which re-act specifically; (2) in saturation experiments with normal sera we are dealing with normal as common opsonics, and these are not specific, since they can be removed by saturation with any one of a considerable number of bodies; (3) in saturation experiments with immune sera we have both the immune and the common opsonics present; the former is quite specific, while the latter is not; (4) *B. pyocyaneus* is quite susceptible to spontaneous phagocytosis.

The consensus of opinion which is to be gathered from the contributions of these several workers attacking the problem from separate points of view is of the utmost importance. On one point there is unanimity *that the estimation of the opsonic index by Wright's method is open to such error as to be useless for diagnosis or treatment.* On another point, those who deal with the subject of treatment are agreed *that vaccine treatment has given such promising results as to justify its continuance.* If these conclusions be justified then a great stimulus to vaccine treatment has been given by freeing it of the dead weight of opsonic control. R.

Diphtheria Bacilli in Normal Throats.—Anna van Sholley publishes a painstaking investigation on the presence of diphtheria bacilli in the throats of healthy children (*Journal of Infectious Diseases*, June, 1907). She examined in the hospitals of New York the throats of 1,000 children, none of whom had been exposed to the infection of diphtheria. From 56 of the 1,000 cases (5.6 per cent.) diphtheria-like bacilli were separated, and in 18 of these (1.8 per cent.) the organism was true virulent Klebs-Löffler bacillus. She also examined the throats of 202 persons who had been in contact with cases of diphtheria. From them diphtheria-like bacilli were isolated 20 times, 14 virulent and 6 non-virulent, or a proportion of 7 per cent. of contacts were infected with the Klebs-Löffler bacillus. The proportion of virulent and non-virulent is, therefore, exactly reversed in the case of contacts from that in the case of non-contacts. The author concludes :—(1) Diphtheria-like organisms are present in a certain number of apparently normal throats, even where exposure to infection cannot be traced. (2) A certain proportion of these organisms (in her cases about one-third) are virulent, and the persons thus infected are a potential source of danger to the community while about two-thirds of the organisms are not true diphtheria bacilli, and are probably harmless. (3) The other conditions being the same, virulent Klebs-Löffler bacilli are found in the mucous membranes of those exposed about four times as often as in those apparently not exposed. (4) Mild sore throats and "colds" with bloody nasal discharge, such as are fairly common in children, should not be lightly considered. Cultures should be taken, and if diphtheria-like organisms are found, their virulence should be tested. R.

Implantation of Cancer.—Butlin in a popular address discusses (*British Medical Journal*, August 3rd, 1907) under the term "The Contagion of Cancer in Human Beings: Autoinoculation," the phenomenon usually known as implantation. He enumerates a fair number of cases which might be explained in this way though some of them are capable of other explanation; but he by no means refers to all the cases well known in the literature of cancer. The sites in which he believes he has evidence of implantation taking place are the vulva, the larynx, the lips, the lower jaw, the uterus and vagina, and some others where the affected points were further distant from each other. R.

Moser's Serum in Scarlatina.—Langowoi and Egis have treated four hundred cases of scarlatina with Moser's serum and have come to the following conclusions :—(1) In the treatment of severe cases the mortality is reduced by the use of the serum from 47.1 per cent. to 16.1 per cent. (2) The serum has undoubted anti-toxic properties. (3) It is of little or no use against the complications of scarlatina. (4) To be of any use it should be injected within the first three days of the sickness, or at latest on the fourth day. (5) The temperature usually falls by crisis when the serum has been given early. In complicated cases, however, a critical fall is not noted. (6) The usual dose of the serum for an adult is 200 c.cm., and for children about half that amount. (7) The different specimens of serum differ widely in their anti-toxic properties. (8) Prophylactic small doses seem to diminish the susceptibility to scarlatina. M.

Chlorosis in Infants.—According to Leenhardt (*Zentralbl. fur Inn. Med.*, 1907. No. 30.) true chlorosis is to be met with in the earliest years of life. He bases this assertion on his own observation of sixteen cases in children between twelve and eighteen months old. The resemblance of the cases to the form of anæmia met with at puberty is often quite obvious. The children are very pale, but with normal development, and are generally in a good nutritional state. With the exception of cardiac murmurs, and murmurs in the vessels of the neck, nothing abnormal can be detected. The liver, spleen and lymph glands are of normal size, but usually there is constipation. The red and white corpuscles are normal in number, both relatively and absolutely, but there is a great deficiency of hæmoglobin. The resemblance to chlorosis of later life is heightened by the fact that improvement rapidly occurs under a course of iron. M.

The Dependence of Respiration upon Pressure Conditions.—As a result of a large number of experiments and from the fact that bilateral pneumo-thorax is not necessarily fatal, Hellin (*Mitteilung a. d. Grenzgebiet du Medizin.* Bd. xvii. Heft, 3 u 4,) claims that the hitherto received theory of pulmonary movements is incorrect. Lung movements he maintains cannot depend upon the difference of pressure upon the inner and outer aspects of the lungs respectively. Clinical observations also agree with this inasmuch as a collapsed lung can again expand even in the absence of a negative pressure. Lungs also may collapse without any preexisting change in the pressure conditions. According to Sauerbruch's investigations in cases of unilateral pneumothorax, it is not the collapse of the lung that proves fatal, but the sudden failure of respiration. Hellin concludes that expiration is not the result of the pressure of the thorax, and that inspiration is by no means necessarily influenced by the adhesion of the lungs to the chest wall. M.

The Blood Pressure in Athletes.—Gordon has investigated the blood pressure before and after exercise (*Edinburgh Med. Journal*, July, 1907). The subject of his observations was a champion club swinger, who had arranged to swing his clubs for twelve hours continuously on six consecutive days. The individual was found to be a perfectly healthy athlete æt. 38. The observations were made by means of a Riva Rocci and an Erlanger's sphygmomanometer; the pressure being taken immediately before and immediately after the exercise. It was found that the pressure was on each occasion raised some 15 mm. after the exercise, but this rise was invariably gone by the next morning. More violent exercise, such as playing football, seems. on the other hand to cause a fall of pressure of about 25 mm. Hg. M.

The Influence of Smoking on the Circulation.—Hesse has systematically examined (*Deutsch. Archiv. fur Klin. Med.*, Bd. 89., p. 565) the blood pressure, systolic and diastolic, and the pulse frequency in smokers, before and after smoking, with the object of determining the influence excited by nicotine on the circulation. He finds that in almost every case a marked rise of blood pressure takes place after smoking, and that this is accompanied by an increase in the pulse rate. The greater the age of the individual, the more marked is the rise. The rise, moreover, is much more evident on the systolic pressure, than on the diastolic. It occurs quite quickly, but does not persist long. Sometimes the aortic sound becomes markedly accentuated during smoking. Hesse concludes that the general effects of nicotine on the circulation are stimulating rather than the reverse, and he thinks that some of the cardiac troubles met with in smokers may be the result of cardiac overstrain. M.

The Metabolism in Arthritis Deformans.—King has studied exhaustively the metabolism of a case of arthritis deformans (*Johns Hopkins Hospital Bulletin*, July, 1907, p. 274), and has come to the following conclusions :—(1) There is undoubtedly taking place in the organism an acidosis, due to organic acids and mild in nature. The actual organic acids were not identified, but it was shown that neither diacetic acid or oxyacetic acid were present; (2) the acidosis is combated chiefly by an increased ammonia production; (3) throughout the course of the experiment there was a retention in the body of calcium, magnesium and phosphates; (4) there was no evidence from the urine of any acid intestinal putrefaction, and the ratio of the aromatic and perfumed sulphates remained about normal; (5) an increase in the organic phosphates in the urine coincides with the increase of organic acids; (6) the disturbance in the elements maintaining the alkalinity of the body was very slight. M.

NOTICES TO CORRESPONDENTS, &c.

☛ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

SOUTH WALES.—We have protested again and again against the habit of journals calling quacks, herbalists and abortionists "doctor," but it seems to make but little difference. The sub-editor and the reporter of the ordinary daily newspaper have little care but for what will make a good head line, and we must trust to time and education to teach them the difference between a quack and a qualified man.

THE ETIQUETTE OF CONSULTANTS TOWARD GENERAL PRACTITIONERS.

GENERAL PRACTITIONER.—The relations between Surgeon B and your patient appear to us to depend on the position in which Surgeon B was placed at the first consultation. If you were prepared to take the management of the case, and if Surgeon B was called in merely to give his opinion at the time and to prescribe treatment, he has acted incorrectly in communicating any facts to the patient save through you, and he was not entitled to see the patient at his house, even if the patient requested him to do so, unless you sanctioned such an arrangement. If, on the other hand, it was arranged at the first consultation that Surgeon B should take on the management of the case, he is, of course, entitled to adopt any precautions he thinks necessary to acquaint the patient of the course of his case, and to see him as often as is necessary. At the same time, however, it would only be courteous and proper on his part to acquaint you at once with any new developments.

DR. G. F. S.—Your communication came to hand as we were "at press"; it will appear in our next.

WEED.—We know that certain efforts have been made to rid tobacco of nicotine, but we believe they have never been thoroughly successful, and no nicotine-less tobacco that we know of has been placed on the market. Dr. Lesieur, of Lyons, is an enthusiast on denicotinisation, and he would doubtless reply to any letter you might address to him.

MR. HY. S.—See reply to Dr. G F. S.

HUMANITARIAN.—Thank you for brochure, which we already know and value. We fancy you cannot have read all our comments, as imprisonment for debt was distinctly and specifically reprobated by us. We hold in horror the practice of sending working men to prison for trumpery debts, and wish you every success in your efforts to put an end to it.

HOUSE SURGEON.—Yes, it has been definitely decided by the Committee that women doctors will be considered no longer eligible for the post.

G. B.—We think that, so far as four-fifths of Ireland are concerned, your religion will effectually prevent you from obtaining any such post as you seek, no matter what your qualifications. So far as the remaining fifth is concerned, your religion might not be a bar, but we doubt if your qualifications would be taken into consideration unless there was no local candidate in the field. Temporary appointments therefore, as a means of leading up to a permanent appointment, do not appear to possess a high value. It may be some consolation to you to know that the appointments you seek are universally considered to be not conducive to the future happiness or welfare of their holders, and that under the present condition of things you will be far better elsewhere.

Vacancies.

Bridgnorth and South Shropshire Infirmary.—House Surgeon. Salary £100 per annum, with board and lodgings in the Infirmary. Applications to the Hon. Secretary, the Infirmary, Bridgnorth.

West Norfolk and Lynn Hospital, King's Lynn.—House Surgeon. Salary, £100 per annum, with board, residence, and washing. Applications to the Chairman at the Hospital.

Leicester Corporation.—Isolation Hospital.—Resident Medical Officer. Salary £120 per annum, with board, lodging, and washing. Applications to C. Killick Mallard, M.D., Town Hall, Leicester.

County Borough of Salford.—Fever Hospital.—Assistant Medical Officer at the Ladywell Sanatorium, Salford. Salary, £150 per annum, with apartments and board. Applications to L. C. Evans, Town Clerk, Town Hall, Salford.

Egyptian Government.—Kasr El Ainy Hospital.—Resident Medical Officer. Salary £250 a year, with quarters, servants, washing, coal, and light. Applications to the Director-General, Public Health Department, Cairo.

York Dispensary.—Two Resident Medical Officers. Salary, £120 a year, with board, lodging, and attendance. Applications to W. Draper, Esq., De Grey House, York.

Loughborough and District General Hospital and Dispensary.—Resident House Surgeon. Salary £100 a year, with furnished rooms, attendance, board, and washing. Applications to Thos. J. Webb, Secretary, Loughborough.

Carlow District Asylum.—Resident Medical Superintendent. Salary, £350 per annum. Applications to John Keenan, Secretary Joint Committee.

National Maternity Hospital, Holles Street, Dublin.—Intern Assistant Physician. Salary, £50 per annum. Applications to the Secretary, Holles Street.

Middlesex County Asylum, near Tooting, S.W.—Fourth Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Southwark Union, London.—Second Assistant Male Medical Officer. Salary, £100 per annum, with board, lodging, and washing. Applications to Howard C. Jones, Clerk, Union Offices, John Street West, Blackfriars Road, S.E.

Devonshire Hospital, Buxton.—House Surgeon. Salary, £100 per annum, with furnished apartments, board, and laundry. Applications to the Secretary.

Canterbury County Borough Asylum.—Medical Superintendent. Salary, £350 per annum, with unfurnished house, coal, light, washing, garden produce. Applications to the Town Clerk, 15 Burgate Street, Canterbury.

Cambridgeshire, etc., Asylum.—Second Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors, Cambridge.

Appointments.

ASH, EDWIN L., M.B.Lond., M.R.C.S.Eng., Clinical Assistant at Great Northern Central Hospital, London, N.

BALL, W. GIRLING, F.R.C.S., Assistant Surgeon to the City of London Truss Society.

COLLINS, E., M.R.C.S., L.R.C.P., District Medical Officer of Bishop's Stortford Union.

GORHAM, P. C., L.R.C.P., L.R.C.S., Certifying Factory Surgeon for the Clifden District, co. Galway.

ELLISON, FRANCIS CHARLES, M.D.Dub., Resident Medical Superintendent, Mayo County Asylum, Castlebar.

GASK, G. E., F.R.C.S., Surgeon to the City of London Truss Society.

HEBB, J. H., M.B., B.Ch.Oxon., B.A., District Medical Officer of Bicester and Headington Unions.

HUSTLER, G. H., M.B., Ch.B.Leeds, Government Medical Officer for Fiji.

LAWSON, T. C., M.R.C.S., District Medical Officer of Stratton Union.

MAIR, GAVIN D., M.B., B.Ch., Resident Medical Officer, Royal Albert Hospital, Devonport.

PAUL, V. G. J., M.R.C.S., L.R.C.P.Lond., District Medical Officer of the Tendring Union.

RIDLEY, T., M.B.Melb., Assistant Resident Medical Officer of the Midwifery Department of the Women's Hospital, Melbourne.

WALFORD, H. R., M.R.C.S., L.R.C.P., Assistant Surgeon to the Coventry and Warwickshire Hospital, Coventry.

WILLIAMS, E. G. H., M.R.C.S., L.R.C.P., District Medical Officer of the Droitwich Union.

Births.

EDWARDS.—On August 28th, at Westcroft, Privett Road, Gosport, the wife of Lieut. G. B. Edwards, R.A.M.C., of a daughter.

LYLE.—On Aug. 30th, at "Uplands," Bournemouth, the wife of Lieutenant-Colonel Allan Lyle, R.A.M.C. (retired), of a daughter.

MACCARTHY.—On August 26th, at Glenaveena, Clooney Park, Londonderry, the wife of Brendan MacCarthy, M.D., D.P.H., Med. Inspect. L.G. Board, Ireland, of a son.

PARSONS.—On August 26th, at 26 Parliament Hill Mansions, N.W., the wife of W. B. Parsons, M.R.C.S., L.R.C.P., of a daughter.

WALKER.—On August 21st, at Yewdale, Lee-on-the-Solent, Hants, the wife of Lewis Walker, M.D.Lond., of a daughter.

Marriages.

CLARE—DORIN.—On August 29th, at All Saints' Church, South Lambeth, the Rev. Mervyn Clare, Minor Canon of St. Canice's Cathedral, Kilkenny, only son of the Rev. Mervyn A. Clare, of Blackheath, to Florence Margaret (Daisy), only daughter of A. F. L. Dorin, M.R.C.S., of 344, Clapham Road, London.

RENTON—BORMAN.—On Sept. 2nd, at All Saints' Parish Church, Bloomsbury, London, Maurice Waugh Renton, M.D., of The Bridge House, Dartford, to Ezma Olivia Borman, daughter of Allen Borman, Esq., Alexandria, Egypt.

WRIGHT—TAYLOR.—On August 28th, at the Parish Church, Lyons, Hetton-le-Hole, near Durham, Archibald Francis Wright, M.B., third son of the late Strethill H. Wright, M.D., of Ganarew, near Monmouth, to Dorothy Mary, daughter of the Rev. R. H. Taylor, D.D., Rector of Lyons.

Deaths.

CROFT.—On August 26th, at Cheam, Surrey, Anna Maria Croft, widow of the late Robert Charles Croft, M.D.

INGLIS.—On August 29th, at 2 East Ascent, St. Leonards-on-Sea, Wilhelmina Simson, wife of Arthur Stephen Inglis, M.D.

WIGGINS.—On August 25th, at Gt. Missenden, Eric, the eldest son of Charles Wiggins, M.R.C.S., L.R.C.P.Lond., of 117 Ladbroke Grove, London, aged 14 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, SEPT. 11, 1907. No. 11

NOTES AND COMMENTS.

The Apprenticeship of Medicine.

OF all the learned professions it may pretty safely be asserted there is none in which the aspirant finds himself faced with greater obstacles than in that of medicine. After being tested as to his general education by preliminary examination he has to settle down to five years of hard and systematic study. At certain intervals his knowledge of the various subjects included in the curriculum is severely tested, and it is only when he has succeeded in satisfying his examiners on all points that the desired qualification to practise is granted. In some instances the student is not able to pass his examinations within the allotted five years and has to spend a further period in study. Oftentimes when he is ambitious of taking the higher degrees and qualifications and of embarking in consultant or specialist practice he deliberately makes up his mind to two or three extra years of pupilage. What with multiplicity of subjects and increasingly higher standards, the students' career, as above outlined, connotes the expenditure of a vast amount of time, energy and money, ere the goal is reached and the fully fledged practitioner enters upon the serious work of his life.

A Noble Profession.

THEN the official sanction having been acquired, the newly fledged practitioner of medicine is launched upon the sea of professional life. The right has been conferred upon him by the State to intervene in the unceasing struggle of mankind against disease and accident and other adverse influences of environment. A cynical French physician, writing some time ago in the columns of THE MEDICAL PRESS AND CIRCULAR, reminded a young friend about to commence practice that his diploma was written on the skin of an ass. On this side of the Channel it would probably be engraved on that of a calf, but in either case it would not interfere with Dr. Cornu's advice to his correspondent not to resent the inference, but rather to regard it as a tacit injunction to be patient, courageous and gentle. For these are high qualities, and they are demanded of all who would be worthy of a noble profession. Yet the conditions of society are such that mere abstract nobility of the kind involved will not become a satisfactory footing for the struggle for existence.

The Financial Aspect of Practice.

THERE is a financial side of the picture, the neglect of which will sooner or later spell ruin to the most ardent enthusiast in scientific work, unless, indeed, he is fortunate enough to be in possession of an independent income. The student can afford to follow science for science's sake; the practitioner, on the other hand, has to practise art for something more than art's sake. It is all very well for medical men, who, by the way, are usually those in possession of a comfortable income, to deplore the spread of trade-union ideas and to deprecate the commercial spirit amongst their medical brethren. There is nothing dishonourable in taking a proper collective care of the financial factors of the situation, which have, unfortunately, in the past been often disregarded, with most disastrous results. It is not as if the State in conferring the right to practise the healing art upon properly qualified men had taken care to protect them against the inroads of unqualified pretenders. Members of Parliament are far too apt to consider that the State has granted an enormously valuable monopoly to the profession and is entitled in return to exact as much gratuitious service as can be wrung from the profession. The more precise statement of the situation is that the State has imposed certain restrictions upon medical men so as to ensure a proper supply of skilled practitioners in the interests of the public. By permitting the competition of a whole host of quacks and patent medicine vendors the State has betrayed the medical profession and abandoned with cynical shamelessness the wholesome principle of the protection of the public safety.

An Instance!

THE State, as we have already said, exacts many gratuitous services from the medical profession. As an example may be taken the death certificate, which is signed by the medical attendant of deceased, and for which no fee is payable. The legal document in question is of importance in many ways, and may form the crucial proof in various lawsuits. From no other profession in the world would the State attempt to exact a similar substantial service without the payment of a suitable fee in return. One may fancy the utter contempt with which the lawyers would resent any attempt to exploit their profession in a similar way. Such and such a fee would be demanded for signature, correspondence would be charged at the rate of six and eightpence a letter, and other work in connection with the required document would be entitled to corresponding rates of remuneration. When it comes to medical men, however, the element of humanitarian kindness is in some extraordinary way confused with the principles that govern an ordinary business transaction, so that the matter usually ends by the required service being rendered "free, gratis, and for nothing." In many ways this must, in the long run, prove a bad bargain for the community, for it is only by maintaining the medical profession in a position of honourable independence, from the point of view of average professional income, that society can hope to maintain a high general standard of professional conduct and competence.

Mr. John Burns and the Birth Certificate.

No more glaring instance of the attitude of Parliament towards the monetary interests of the medical profession could be obtained than that afforded by the recent Notification of Births Bill. Under the guidance of Mr. John Burns the measure has passed into law. It provides for the future notification of all births, an obviously salutary measure, but it makes no provision for the payment of the medical man who sends the necessary intimation. At one stage of the proceedings in the Commons it was determined to pay the medical attendant the magnificent sum of one shilling for each signature! At a later stage of the proceedings, however, even that frail sum vanished into thin air, and Government, following the hallowed precedent of centuries, have framed a law whereby the medical practitioner, under pain of various penalties, is compelled to sign a responsible document giving information obtained *in his professional capacity* without fee or reward. The incredible meaness of this transaction is not what one would have looked for from the President of the Local Government Board, who, of all men, we should expect to recognise the principle that the labourer is worthy of his hire. The medical members of Parliament in the House protested against the measure, but they were not numerically strong enough to prevail. The lamentable lack of medical representatives in the Commons was never more disastrously in evidenece than in the passage of Mr. John Burns' memorable Notification of Births Bill.

The Moral of the Matter.

The above is written in no spirit of mere discontented grumbling or of unbelief in the future welfare of what is justly termed a "noble profession." It is written, however, in the firm belief that Heaven helps those who help themselves. From that standpoint we would urge the medical student from the outset of his career to pay careful attention to all organisations that are directed to the task of protecting the material interests of the profession to which he belongs. There are various ways in which the general welfare of medical men may be forwarded. In the forefront of these agencies we should place that of legislation against quacks and quackery. For many years past it has been our mission to urge the desirability of such preventive action not only in the interests of medical men but also in those of the great outside public. Of late we have added to our programme the suggestion of a Royal Commission to enquire into the terrible abuses and injury sustained by the public at the hands of quacks and patent medicine vendors. We are glad to say that the pharmaceutical profession, as a whole, is making efforts in the same direction. During the year we hope to bring this matter of a Royal Commission before the profession and the public in concrete form.

For the Purpose of Acquiring Manual Skill.

The attitude of the State—*alias* the community—towards medical men is curiously illustrated by the laws passed to control vivisection. The very title of the measure—"The Cruelty to Animals Act"—begs the question, because it tacitly implies that all vivisection is cruel. With the merits or demerits of the controversy we are not here concerned. Briefly the attitude of scientific medicine is that experiments on living lower animals are necessary to elucidate many processes of physiology and pathology; that they have rendered priceless service in the past to medical progress; and that, properly guarded, they are absolutely warranted from a moral point of view in the interests of mankind. In the above-mentioned Act experiments calculated to give pain to living vertebrate animals are prohibited under various specific restrictions. Amongst the latter is one that says they must not be performed for the *purpose of acquiring manual skill!* A man may maim rabbits, hares, and partridges *ad libitum* until he becomes a good shot—but a surgeon must acquire his skill from patients. So says the law—the wise law—the law passed to satisfy the sentimental anti-vivisectionist. The satire of it all is that even anti-vivisectionists want surgical operations, and then—then—why, they have them, and their lives are saved as the outcome of vivisection!

Tact.

Many things wanted to ensure success in practice are not taught in the schools. Devotion to duty is one of them; not only the patient self-sacrifice, and the holding to right because it is right, but the less exalted form which is prized by the public, namely, that of promptitude, and of careful attention to the history of symptoms, however detailed, minute, and wandering. The latter point is one of the manifold skilful strokes in the game that in their entirety constitute that evasive quality which we all know as "tact." Sooner or later, it may be at the cost of dire experience, that faculty has to be acquired by the medical man who would succeed in the exercise of his profession. To quote once more from Dr. Cornu, "Practising for the public an art which it is incapable of judging, you must not hope to create an impression by your knowledge of disease, but by your knowledge of men. The more illusions you have brought into your career the more will the reality have bruised your delicacy of intelligence and sentiment, the deeper will be your fall, and the more dangerous the depression which experience is holding in wait for you."

The Rosy Side.

There is a rosy side to the professional life of the medical practitioner, in spite of quacks and quackery, of anti-vaccinators and anti-vivisectionists, of bad debts, of harassing work, of hospital competition, and of the score of other rocks and shoals that strew the sea of practice. The profession is honourable and intellectual: it is one becoming the traditions and the character of a gentleman: it is humane, charitable, it is progressive, it is intellectual, and, above all other callings in life, it is essentially human. Well may the line of Terence—*Homo sum, humani nil a me alienum puto*—be adopted by the liberal-minded and zealous practitioner of medicine. Yet must he follow his ideal with no divided affections. The work of his profession must be his life-work—to be pursued with whole-hearted devotion to the last day of his life. Nor is the chance denied to the most remote and humble follower of medicine of contributing some fresh discovery or observation of value to the sum total of medical achievement. We have but to remind ourselves that some of the great things in medicine have come from country practitioners.

The Approach of Cholera.

Cholera is markedly on the increase in Russia. It has taken the usual course, and is mounting up the Volga, leaving a train of victims in its rear. That important centre, Nijni Novgorod, has now been invaded, fifty-five cases, with seventeen deaths, being reported there within the last few days. Nijni Novgorod is a large trading centre, and there is constant communication between it and Germany, so that the authorities in the latter country have naturally taken alarm, and rigid inspection of travellers is taking place at the frontier. Inspection, however, in the case of cholera, is not of much service, as the germs of the disease may be latent in a person in apparently good health, but who may rapidly become a source of extreme danger to others. Now that communication between India and Russia is being opened up more freely, the chances of the dissemination of cholera are correspondingly increased, and it may be expected as almost a normal autumnal event in the future for the disease to pass into South-East Europe. Probably, however, the outbreaks, although more frequent, will not attain the terrible proportions of the epidemics of 1869 and 1892, which created such havoc in European countries, and this country is certainly safe this year from any risk of serious incursion. On the other hand, however, while India remains the endemic centre of cholera, it will be one of the burdens of the Empire to seek to limit the excursions of the disease, and its rulers must, among their other troubles, seek to grasp the enormous responsibility that rests on them in the matter.

CURRENT TOPICS.

Public Health in Ireland.

The complacency with which the various public bodies, charged with the control of public health in Ireland, regard their own petty actions would be amusing were it not tragic. With urban death-rates among the highest in Europe, with infantile mortality out of all relation to the occupation of the people, with tuberculosis decimating the youth of the country, every sanitary authority persistently plumes itself on its energy and efficiency. In a debate in the Dublin Corporation, last week, we find a Mr. Clancy boasting that "out of chaos was evolved a city that they were all proud of. Out of a city of dirt and squalor and filth there had been produced a city that they were not ashamed to have people visiting." We fear it is true that Mr. Clancy and his friends are not ashamed that the death-rate in Dublin County Borough last year was 25 per 1,000, that the streets of the city are the filthiest of any city in the Kingdom, that every branch of sanitary work is neglected. If shame were felt at these things, there would be more hope of improvement. It is not the election bodies alone, however, which are to blame. The Local Government Board, whose duty it is to lead and advise the local bodies, is as boastful as Mr. Clancy and as inert as the meanest district council. Their representatives at a conference concerning tuberculosis a week or two ago declared proudly that the Local Government Board was fully awake to the serious nature of the tuberculosis problem. The evidence of their wakefulness was the issue of their circular during the course of the past thirty-six years'. In 1906, 11,756 persons died in Ireland of tuberculosis.

PERSONAL.

Dr. William Ewart will deliver the annaul inaugural address at St. George's Hospital, on Tuesday, Oct. 1st, the subject being "Res Medica, Res Publica." The annual dinner will be held at 7 p.m., the same evening, at the Whitehall Rooms, Hotel Metropole.

Colonel P. H. Benson, I.M.S., has been appointed Principal Medical Officer of the Secunderabad Brigade.

Professor Osler, M.D., F.R.S., will give the introductory address at St. Mary's Hospital Medical School on October 2nd.

The Volunteer Decoration has been awarded to Surgeon-Major C. A. MacMunn, 3rd (Vol.) Battalion of the South Staffordshire Regiment, and to Surgeon-Major George Hollier, 2nd (Vol.) Battalion of the Shropshire Light Infantry.

Miss Alice Brunton, daughter of Sir Lauder Brunton, has been awarded the diploma of Officier de l'Instruction Publique by the French Minister of Public Instruction, in recognition of her services to the late International Congress on School Hygiene.

Dr. D. Newman, Dr. D. C. McVail, Dr. J. C. Renton, Dr. D Macartney, and Dr. James Barras have been appointed medical referees for Lanarkshire under the Workmen's Compensation Act, 1906.

By the retirement of Colonel James Magill, M.D., C.B., the Royal Army Medical Corps will be deprived of the services of a most capable officer, whose many years of good work in Egypt and the Transvaal and other parts of the world, has been highly appreciated.

We have much pleasure in recording the rescue of a lady from drowning by Dr. Alfred Walker. The incident occurred at Port Gaverne, in Cornwall, and Dr. Walker, who was bathing at the time, pluckily proceeded to the spot where the lady sank and succeeded in bringing her to shore

By the will of the late Mr. William Marsh, the West Bromwich District Hospital has benefited to the extent of £1,000, while the Birmingham General Hospital and the Queen's Hospital, Birmingham, receive £350 each.

On September 5th the Ashton Board of Guardians passed a resolution viewing with surprise and alarm the utilisation by the Corporation of the isolation hospital for the treatment of so highly infectious a disease as scarlet fever, having in view the close proximity of the workhouse!

The will of the late Sir William T. Gairdner has been proved at £11,255, of which £2,604 were derived from insurance policies.

EDUCATIONAL SUMMARY FOR 1907-8.

INTRODUCTORY REMARKS.

If the pursuit of medicine is judged by the sneers of latter-day cynics like Bernard Shaw, or the bludgeon-blows of literary aliens like Maartens Maartens, it would appear to be a particularly mean and sneaking method of extracting coin out of the pockets of wealthy fools. But these gentlemen and others of their kidney have little title, as far as we can gather, to formulate indictments against a profession with whose members and whose work they must be strangely unfamiliar. Superior persons who wish to impress their generation with an idea of their transcendent perspicacity find a short and easy method of doing so to consist in sweeping all the dirt they come across into one corner of a room, and pointing to that as a sample of the condition of the floor. A better and more effective method of arriving at the true estimation in which a calling is held is to apply to the average man, who lives an average life, and has no wish to twinkle in the literary firmament as a star of the first order. It may pretty safely be laid down that the average man looks to his doctor not only as a trusty counsellor, but as a particularly good friend in time of trouble, and the practical reliance of such a man on his medical adviser is a better testimony to the latter's worth than all the problem-plays and six-shilling novels of a lustrum. It is a fact, and one worth noting, that in ordinary middle-class and upper middle-class society a medical man is not only always sure of a cordial reception, but he is always regarded among his patients as a peculiarly intimate friend, and one whom they are especially pleased to honour. Now, inasmuch as a medical man has no ready-made position of authority such as has a clergyman, nor the prestige of one of the destructive professions, such as the army or navy, nor the prospect of wealth that may be garnered from business, but simply his own attainments and personality to rely upon, it follows that the calling of medicine must attract men of higher potentiality than other lines of life, and endow them with an unusual degree of urbanity and kindliness, for them to attain such a position as we have indicated. If the ordinary general practitioner were possessed merely of a technical knowledge of bodily ailments, he might find rank and comradeship proportioned to his special attainments, but he would not gain that all-round respect or friendliness which is undoubtedly his. The cause for this social estimation lies largely in the humanising influence that the practice of medicine exerts on its followers; the knowledge of men and women at their best and at their worst, a knowledge which fails to make doctors cynics, but succeeds in making them sympathetic friends. They know how much may reasonably be expected of human nature, and are not soured with mankind when they find the popular general on his sick-bed wincing before the scalpel, the philanthropic peer grumbling at the flavour of his medicine, the anti-vaccinationist tub-thumper slinking round after dark to have the poisoned lymph inoculated in his arm, or the blatant anti-vivsectionist begging for antistreptococcic serum when he has a cut on the finger. All these things come in his day's work, and he early learns that disillusionment is a matter for happy mirth rather than for acid sarcasms on his fellows and their shortcomings. Moreover, his work soon shows him more clearly than that of anyone else where true valour and real goodness are to be found. He knows that the plucky little mother who labours for her family of six, and wears a perpetual smile, is never free from pelvic trouble that no one guesses at, and he knows that the shuffling shopman, whose clumsiness excites the ire of his customers, is making a brave struggle not to let his mitral disease break up the business he has put together himself. In the doctor's view of life the mother and the shopman more than outweigh the shrinking general and the testy lordling. The reward of the medical man's work and the pleasure of his existence is to be measured, then, by the benignity he acquires as he grows older, and certainly not by his balance, if balance there be, at the banker's. The man who sets out in practice with the intention of making a fortune and "founding a family" is rapidly undeceived; the conditions of work and its remuneration leave no scope for such tokens of worldly success. If, through a happy combination of private means, professional success, and influential friends he finds himself attached to the Court and the recipient of a baronetcy, the highest external honours available for a medical practitioner will have been attained, but he will figure but ignominiously in the eyes of society when he sits down to dinner with an Archbishop, a Lord Chancellor, a Field Marshal, a belted brewer, and a bacon king. In fortune, in influence, in importance in the councils of the State, the medical man can compare with none of these.

Let him make his goal, then, the accomplishment of small things and the advancement in the degree nearest his hand of the sum-total of medical knowledge. Let him seek to be an accomplished and resourceful practitioner, willing and able to lend a hand at any time and place to the sick and sorry, and to his brother practitioner; aiming at making an honest livelihood through upright and sturdy methods, and not hoping what he can never expect, namely, to rise to dignities and honours which are reserved for other callings than that of tending the sick.

CHOICE OF A SCHOOL.

The first decision that a student has to make, once he has irrevocably mated himself to the study of medicine, is as to where he shall carry out his intention. He would indeed be ungrateful if he grumbled that a wide enough choice was not provided for him, for with fifteen or sixteen Universities in the British Isles, many of them provided with several constituent schools, surely only a misanthrope could complain that his tastes, wishes, and predilections were not catered for. As practically all these Universities and schools are badly off for money, and not too rich in students, he may calculate on finding himself welcomed wherever he finally decides to go, which is indubitably an advantage at the outset of a career. There is, as a rule, a certain tendency for a man to look to his immediate vicinity for the maturing of his genius, and in these days, when Universities are cropping up with bewildering prolixity, most students will probably find one within fifty or sixty miles of their homes. As the medical curriculum is laid down carefully by the General Medical Council, there is not much variation in that of the individual schools, and a good all-round education can be relied on in practically every one. On the other hand, some have teachers of established ability and reputation, whilst others are seeking to obtain that enviable notoriety, and while some men may be attracted by the spirit of adventure to cast in their lot with the new and struggling, others will prefer the security of well-trodden paths. The object of this number of The Medical Press and Circular is to present impartially the claims and attractions of all schools, and if parents and their wards study its pages carefully they will, we feel sure, be convinced that there are none that have not their own special charms. The outlay on actual necessary educational expenses does not differ very materially in different places, the higher cost of certain centres being chiefly due to the greater cost of living. It is obvious that in London, for instance, where rents are high, the cost of lodgings must be considerably more than in many smaller and less favourite towns, while, on the contrary, a student living in his parents' home in London will not be so much expense to them if he goes to a London Hospital as if he takes up his abode at a northern university. But, other things being equal, it is a most important point for the average student to choose that school at which he is most likely in after years to obtain a resident post, and in this vital respect some of the less fashionable schools can present much greater advantages to the average man than can their more popular rivals.

Choice of Qualifications.

In a millennial state the question of the choice of qualifications will not arise, as every man will either be a doctor or not a doctor, without further ado. It so happens, however, that in the course of ages, among the anomalies surrounding the practice of the art of medicine, there have grown up a number of rival interests, both pecuniary and scholastic, which it is very difficult to break down, with the result that students are offered all sorts of qualifying diplomas, conferring on them the right to append almost every conceivable alphabetical combination to their names. It may be laid down in general terms that the shortest and least picturesque of these designations will generally be found the most serviceable, both from the expenditure of time that it will save in signing certificates, and in the greater ease by which it will be understanded of the people. Happily, or unhappily, a qualification even of the highest order has, as a rule, but small relation to success in practice, and many practitioners of light and leading will be found to have laid the foundations of their success on a more solid basis than that of academical triumph. The degree of M.D. of a British university should be the ordinary hall-mark of a British practitioner as much as a native M.D. is of his American *confrère*, but while those holding such a degree consider their market value would be lowered by its being "cheapened," the south countryman will be placed at a certain disadvantage as compared with his northern rival.

Course of Study.

Although there are certain individual variations, the course of study pursued at all the medical schools is pretty much the same. One or two of the universities are a little exacting in the number of special subjects they pile on to the crouching backs of their alumni, but in course of time it is generally found that the other centres of instruction follow their lead. Still, it is well to remember that from the moment the student pays his fee to the dean the disposition of each moment of his time for the next five years has been laid down with procrustean exactness, and that any diversion in the shape of amusement, illness, or failure in examination connotes a corresponding addition to the length of his pupilage.

Choice of Career.

The freshly-qualified man has the world open before him, and he may content himself with the reflection that his skill will be of as much service in Greenland's icy mountains as on India's coral strand, and he can ply his art with as beneficent results, though not with equal financial advantage, in Bethnal Green as in Grosvenor Square. He can therefore consult his predilections in some degree as to where he will practise his profession, though he will probably find the choice somewhat narrowed by the pecuniary resources at his disposal and the meagre opportunities offered for enterprise in the vicinity of popular, established practitioners. If he be averse from the struggle for existence in the troubled waters of private practice, he may turn to the comparative haven of competency afforded by the services. The Army, Navy, Indian, Colonial, and West African appointments may tempt him abroad, or the poor-law infirmaries, lunatic asylums, public health officerships, or fever hospitals may prevail on him to remain at home. In all the official Government services there is a career, even if a limited one, with graduated promotion and certain pension, whilst in the local services at home promotion is very uncertain, the pay, except in a few instances, very poor, and a pension either not provided or calculated on a studiously thrifty basis. One of the special advantages of medicine is that its votaries are nearly always sufficiently in request to be able to pick up a living as long as health lasts, but the prospects it affords of an old age of dignity and ease earned by professional diligence alone are somewhat dim.

Summary.

Medicine, then, may be recommended chiefly to those who have a strong turn for prying into the hidden things of nature, and find great pleasure and refreshment in so doing. To such the profession of healing will offer numberless opportunities for applying their peculiar powers, and will give much entertainment by the elusiveness of its secrets. The other class of man who finds satisfaction in the practice of medicine is he who regards the welfare of others before his own comfort and convenience. These rare beings, less rare probably in the medical profession than in any other, make devoted practitioners among the poor, and do not account their labour wasted if their patient gets well but cannot afford through stress of his illness to pay his bill. The man who does not get on well at medicine is he who wishes to account for all his services on a cash basis, and to make his practice a purely business concern. As a matter of fact it is not possible to translate personal services into an exact money equivalent, and much unpleasantness pursues the path of him who tries to do so. The best that many men hope for is that a reasonable number of honest and grateful people will be found so far to appreciate his services that he is relieved of financial strain for the next half-year. Those who make ample incomes in medicine are few, and the rush only lasts a few years. The man who enters the medical profession as a path to fortune is by way of being disappointed, though he who seeks an honourable competency has a fair chance of obtaining it.

THE ENGLISH UNIVERSITIES.

The English Universities are nine in number, *viz.*, Oxford, Cambridge, London, the Victoria, Durham, Liverpool, Leeds, Sheffield and Birmingham. The choice of a University is usually determined by social, geographical, and financial considerations. Students whose parents are able and willing to incur the necessary expense will do well to select one of the ancient Universities, since their degrees confer upon their holders a status not accorded by the public to the degrees of more modern institutions. To those less favoured by fortune, but blessed with energy and a fair share of intelligence, the London

University offers ample scope, and its degrees are recognised as the outward and visible sign of high professional attainments. A capable and industrious student, however, may equally well lay the foundations of success in one of the newer provincial Universities.

OXFORD.

There are two degrees in medicine, B.M. and D.M., and two degrees in surgery, B.Ch. and M.Ch. The B.M. and B.Ch. degrees are granted to those members of the University who have passed the second (B.M.) examination. Graduates in Arts, B.A., are alone eligible for these degrees. In order to obtain the degrees of B.M. and B.Ch., the following examinations must be passed:—1. Preliminary: Subjects:—Mechanics, and Physics, chemistry, zoology, and botany. 2. Professional (*a*) First examination (held twice a year): Subjects:—Organic chemistry, unless the candidate has obtained a first or second class in chemistry in the Natural Science School; Human physiology, unless he has obtained a first or second class in animal physiology in the Natural Science School; Human anatomy; Materia medica with pharmacy. (*b*) Second examination: Subjects:—Medicine, surgery, midwifery, pathology, forensic medicine with hygiene. The approximate dates of the examinations are as follow:—Preliminaries:—Physics, chemistry, and botany, December and June; Zoology, March and June; Professional (First and Second B.M.), June and December.

The degree of D.M. is granted to Bachelors of Medicine of the University who have entered their thirty-ninth term on presenting a dissertation approved by the appointed professors and examiners.

The degree of M.Ch. is granted to Bachelors of Surgery of the University who have entered their twenty-seventh term, who are members of the surgical staff of a recognised hospital, or have acted as dresser or house surgeon in such a hospital for six months, and who have passed an examination in surgery, surgical anatomy, and surgical operations. This examination is held annually, in June.

Diploma in Public Health.—The examination for the Diploma is held about the end of November in each year, and is open to any registered medical practitioner, whether he be a graduate of the University of Oxford or not. It is conducted according to the statutes and regulations of the University, and these have been framed so as to be consonant with the Resolutions and rules adopted by the General Medical Council for Diplomas in Public Health.

There are many valuable prizes and scholarships, details of which may be obtained from the University Calendar.

The examination consists of two parts. In the first of these candidates are required to exhibit a knowledge of chemistry and physics in the relations of these sciences to Public Health. In the second part of the Examination the candidate is examined in the subjects of general hygiene and of pathology in its bearings on Public Health. In all the subjects the Examination is partly practical. Candidates may offer themselves for the two parts of the examination on the same occasion or on different occasions; but their admission to the second part is contingent on their having already satisfied the examiners in the first part.

Candidates who desire to prepare for the examination within the University will be afforded facilities for doing so in the laboratories of the scientific departments concerned with the subjects of examination; and arrangements can also be made for candidates to acquire a practical knowledge of the duties of Public Health administration under the supervision of the Medical Officer of Health for the City of Oxford. Information on these points may be obtained by application to the Regius Professor of Medicine, University Museum, Oxford.

UNIVERSITY OF CAMBRIDGE.

At the University of Cambridge five years of medical study are required for the M.B. and B.C. degrees. The candidate must have resided nine terms (three years) in the University, and have passed the "previous" examination in classics and mathematics. There are three examinations: The first in (1) chemistry and physics, and (2) biology; the second in human anatomy and physiology; and the third in (1) pharmacology and general pathology, (2) in surgery, midwifery, and medicine. The first and the third examinations are divided into two parts, which can be taken separately. Subsequently to the third examination an Act has to be kept which consists in reading an original thesis, followed by an oral examination on the subject of the thesis. As the subjects for the examination for the degree in surgery are included in the third examination for the M.B. degree, candidates are admitted to the degree of Bachelor of Surgery on passing the third examination for Bachelor of Medicine.

The M.D. degree may be taken three years after the M.B. An Act has to be kept, including the presentation of an original thesis, with oral examinations and an essay to be written extempore. There is also the degree of Master of Surgery, for which the candidate, having already passed for B.C., or being M.A. has otherwise qualified in surgery, has to pursue extra study in surgery, and has a special examination or submits original contributions of merit to the science or art of surgery. The yearly expenditure of a student who keeps his term by a residence in a college is from £150 to £200 a year. This, however, may include all payments to the University and the College—all fees as well as clothes, pocket money, travelling expenses, &c. Non-collegiate students have only to pay the University fees, which are not large. They lodge and board as they like; their expenses, therefore, are entirely in their own hands.

The University grants a diploma in public health without the necessity of residence, the examination being in so much of State Medicine as is comprised in the functions of officers of health, and subject to the latest requirements of the General Medical Council. These examinations are held in Cambridge the first week in April and October. Candidates, whose names must be on the "Medical Register" of the United Kingdom, and need not be members of the University, should send in their applications to the Secretary of the State Medicine Syndicate a fortnight in advance. Every candidate who has passed both parts of the examination to the satisfaction of the examiners will receive a testimonial testifying to his competent knowledge of the subjects comprised in the duties of a medical officer of health.

There is also a special examination in Tropical Medicine and Hygiene, held annually in August. It is open to qualified practitioners under certain conditions as to previous study and experience. Successful candidates receive a University Diploma.

An abstract of all Regulations may be obtained upon sending a stamped directed envelope to the Assistant Registrary, Cambridge. Full information is contained in the University Calendar.

UNIVERSITY OF LONDON.

The Medical Faculty grants the degrees of Bachelor of Medicine and Surgery, Doctor of Medicine and Master in Surgery. Under the new regulations the students are divided into "Internal" and "External." An internal student is one who has matriculated at the University and is studying in a school approved by that body, or under the teachers of the University. An external student is one who has adopted an alternative course of study. The regulations differ somewhat in their application to the two groups of students. We only propose to deal with them as they affect *internal* students, since the special information required by the others had best be obtained direct from the Registrar. Under no circumstances will a student be admitted to the final examination for a degree until at least five years have elapsed since matriculation or other examination entitling to registration as a medical student.[*]

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[*] May obtain registration as Internal or External students on presentation of documentary evidence as to their condition and a payment of £2; Graduates of such British, Colonial, and foreign Universities as are approved by the Senate for that purpose, and those who have

The Matriculation Examination takes place thrice yearly—in January, June (or July), and September. Application for admission to it must be made on a special form about six weeks beforehand, and the candidate must have completed his 16th year at the date of the examination. Candidates must show a competent knowledge of five subjects, among which *must* be English and elementary mathematics.

The Preliminary Scientific Examination takes place twice in each year, in January and July, and consists of papers on inorganic chemistry, biology, and physics, and there will be a practical examination in each subject. Examiners will also be at liberty to test candidates *viva voce.* A student may present himself for examination in each of the three subjects, separately or in all at the same time. Part I. of this examination includes papers in inorganic chemistry, physics, and biology, with practical examinations; Part II. is an examination in organic chemistry. Six months must elapse after passing Part I.

The Intermediate Examination in Medicine will take place twice a year, January and July. Candidates must have passed the Preliminary Scientific Examination at least two years previously. The subjects of examination are Anatomy, Physiology and Histology, and Pharmacology, including Materia Medica. Candidates who have failed in one subject only at this examination may offer themselves for re-examination in that subject, if permitted to do so by the examiners. Three scholarships, one of the value of £40 in Anatomy, another of the same amount in Physiology, and one of £30 in Pharmacology may be awarded by the examiners to any candidate who has passed the whole of the examination at one time.

Provincial Examinations for Matriculation.—These examinations are appointed by the Senate from time to time upon the application of any city, institution, or college desiring to be named as a local centre for one or more examinations in London under the supervision of sub-examiners also appointed by the Senate. Candidates wishing to be examined at any centre must give notice upon their forms of entry to the Principal of the University. Besides the University fee a fee usually varying from £1 to £3 is charged by the local authorities and must be paid *at the local centre* before the commencement of the examination.

The Final M.B., B.S. Examination takes place twice a year, in October and May. No candidate is admitted to this examination unless he has completed the course of study prescribed in the schedule or in less than two academic years from the date of passing the Intermediate Examination in anatomy and physiology.

The subjects of the examination are Medicine (including Therapeutics and Mental Diseases), Pathology, Forensic Medicine and Hygiene, Surgery, and Midwifery and Diseases of Women. The subjects may be divided into two groups, one of which shall comprise Medicine, Pathology, Forensic Medicine and Hygiene; and the other Surgery, Midwifery and Diseases of Women. Either group may be taken first at the option of the candidate, or the groups may be taken together.

Doctor of Medicine.—The examination for the degree of Doctor of Medicine is held twice a year, in December and July. Every candidate must have passed the examination for the M.B., B.S., of this University. Candidates may present themselves for examination in one of the following branches: (1) Medicine, (2) Pathology, (3) Mental Diseases, (4) Midwifery and Diseases of Women, (5) State Medicine: and if they wish, may pass also in another branch at a subsequent examination. Candidates for Branches 1 to 4 who have taken honours at the M.B., B.S. examination in the subject in which they present themselves for the M.D. degree, or who, subsequently to taking the M.B., B.S., have conducted a piece of original work approved for the purpose by the University, or have had special experience approved by the University, may present themselves for the M.D. examination one year after taking their Bachelor's degree. Candidates in Branch 5 (State Medicine) must show that they have taken the degrees M.B., B.S. not less than two years previously, and that subsequently to taking those degrees they have had (1) six months' practical instruction in an approved laboratory; (2) six months' practical instruction from a medical officer of health, of which three must not coincide with the laboratory work, and three months' practice at a hospital for infectious diseases. The interval between passing the M.B., B.S. and proceeding to the M.D. State Medicine may be reduced to one year, subject to conditions corresponding to those affecting Branches 1, 2, 3, and 4.

Master of Surgery.—The examination for the degree of Master in Surgery will take place twice in each year, commencing on the same dates as the foregoing, and the general regulations already quoted with regard to the M.D. will practically apply to it, surgery being substituted for medicine. The examination will consist of (1) two papers on surgery (one of which may be a case for commentary); (2) an essay to be written on one of two subjects which may be selected from any branch of surgery; (3) two papers on surgical pathology and surgical anatomy; (4) a clinical examination; (5) operations on the dead body; (6) a *viva voce* at the discretion of the examiners. Competent knowledge in every subject of the examination must be shown in order to pass.

Fees.—For Matriculation, £2 for each entry. Preliminary Scientific Examination.—Part I: £5 for each entry to the whole examination, and £2 for each subject when less than the whole examination is taken at one time. Part II.: No fee for first entry, £2 for each subsequent one. Intermediate Examination.—£10 for each entry to the whole examination, and £5 for re-examination in one subject. M.B., B.S. Examination —£10 for each entry to the whole examination, and £5 for examination or re-examination in either group. M.D. and M.S. Examinations.—£20 for each entry.

This University has established centres for preliminary and intermediate studies at University and King's Colleges, and students who purpose taking the London degree should make themselves acquainted with the details attached to external and internal students. Information on these points may be had of the Academic Registrar, University of London, South Kensington.

UNIVERSITY OF DURHAM.

One diploma and six degrees in Medicine and Hygiene are conferred, *viz.*, the degrees of Bachelor in Medicine, Bachelor in Surgery, Master in Surgery, Doctor in Medicine, Bachelor in Hygiene, and Doctor in Hygiene, and Diploma in Public Health. These degrees are open to both men and women.

For the degree of Bachelor in Medicine (M.B.) there are four professional examinations. The subjects for the first are: Elementary anatomy and elementary biology, chemistry, and physics. For the second: Anatomy, physiology, materia medica, therapeutics, and pharmacology. For the third: Pathology, medical jurisprudence, public health, and elementary bacteriology; and for the fourth: Medicine, clinical medicine and psychological medicine, surgery and clinical surgery, midwifery, and diseases of women and children.

It is required that one of the five years of professional education shall be spent in attendance at the University College of Medicine and the Royal Victoria Infirmary, Newcastle-upon-Tyne. First and second year students (dating from registration) are not required to comply with the regulation regarding attendance on hospital practice. Candidates who have passed the First and Second Examinations of the University will be exempt from the First and Second Examinations of the Conjoint Board.

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passed all the examinations required for a degree in those Universities, also women who have obtained Tripos certificates granted by the University of Cambridge, and women who have obtained certificates showing that, under the conditions prescribed by the Delegacy for Local Examinations at Oxford, they have passed the Second Public Examination of that University or have obtained honours in the Oxford University Examination for Women in Modern Languages, and students who hold the Scotch School Leaving Certificate, having passed on one and the same occasion, in the Higher or Honours Grade in all the subjects required by the regulations for the Matriculation Examination.

For the degree of Bachelor in Surgery (B.S.) every candidate must have passed the examination for the degree of Bachelor of Medicine of the University of Durham, and must have attended one course of lectures on operative surgery, and one course on regional anatomy. Candidates will be required to perform operations on the dead body, and to give proof of practical knowledge of the use of surgical instruments and appliances.

For the degree of Master in Surgery (M.S.) candidates must not be less than twenty-four years of age, and must satisfy the University as to their knowledge of Greek or German. In case they shall not have passed in either of these subjects at the Matriculation Examination for the M.B. degree, they must present themselves at Durham for examination in it at one of the ordinary examinations held for this purpose before they can proceed to the higher degree of M.S. They must also have obtained the degree of Bachelor in Surgery of the University of Durham, and must have been engaged for at least two years subsequently to the date of acquirement of the degree of Bachelor in Surgery in attendance on the practice of a recognised hospital, or in the naval or military service, or in medical or surgical practice.

For the degree of Doctor in Medicine (M.D.) candidates must be of not less than twenty-four years of age, and must satisfy the University as to their knowledge of Greek or German. In case they shall not have passed in either of these subjects at the Matriculation Examination for the M.B. degree, they must present themselves at Durham for examination in it at one of the ordinary examinations held for this purpose before they proceed to the higher degree of M.D. They must also have obtained the degree of Bachelor of Medicine of the University of Durham, and must have been engaged for at least two years, subsequently to the date of acquirement of the degree of Bachelor of Medicine, in attendance on the practice of a recognised hospital or in the naval or military services, or in medical or surgical practice.

Each candidate must present an essay which has been prepared entirely by himself, and which must be typewritten, based on original research or observation, on some medical subject selected by himself, and approved by the Professor of Medicine, and must pass an examination thereon, and must be prepared to answer questions on the other subjects of his curriculum, so far as they are related to the subjects of the essay.

For regulations for degrees in Hygiene and for the diploma in Public Health see Calendar 1907-8.

Candidates for any of the above degrees must give at least twenty-eight days' notice to the Secretary of the College of Medicine, Newcastle-on-Tyne. In the case of the M.D. (Essay) Examination, candidates must send in their essays six weeks before the date of the examination.

A new wing has been added to the College of Medicine to accommodate the departments of physiology and bacteriology. It also contains students' union rooms and gymnasium.

The New Royal Victoria Infirmary, containing 400 beds, was recently opened by H.M. the King. In the new infirmary adequate accommodation is provided for the study of the various special subjects, in addition to the ordinary clinical work. Practical midwifery can be studied at the Newcastle Lying-in Hospital. Opportunities for practical study are also afforded by the Dispensary, City Infectious Diseases Hospital, Eye Infirmary, and at the Northumberland County Lunatic Asylum.

There are various appointments open to students, whilst the scholarships available are numerous and of considerable value.

Fees.—(*a*) A composition ticket for lectures at the college may be obtained—1. By payment of 72 guineas on entrance. 2. By payment of 46 guineas at the commencement of the first sessional year and 36 guineas at the commencement of the second sessional year. 3. By three annual instalments of 36, 31, and 20 guineas, respectively, at the commencement of the sessional year. A Composition Ticket for the course of lectures and practical work of the first two years of the curriculum may be obtained by the payment of 40 guineas on entrance. (*b*) Fees for attendance on hospital practice: For three months' medical and hospital practice, five guineas; for six months, eight guineas; one year, twelve guineas composition fee in one payment, twenty-five guineas; or by three instalments at the commencement of the sessional year, *viz.*, first year, 12 guineas: second year, ten guineas; third year, six guineas; or by two instalments, *viz.*, first year, fourteen guineas; second year, twelve guineas. In addition, two guineas yearly up to three years must be paid to the Committee of the Royal Infirmary.

Residence can be had in a separate hostel for female students at moderate inclusive fees for board, &c., particulars of which and any other college information will be given on application to Prof. Howden, Secretary, University of Durham College of Medicine, Newcastle-on-Tyne.

MANCHESTER UNIVERSITY.

Candidates for degrees in medicine and surgery must attend classes in the University during at least two years.

The Degrees in the Faculty of Medicine are Bachelor of Medicine (M.B.), Bachelor of Surgery (Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). All candidates for Degrees in medicine and surgery are required to pass the Matriculation Examination, or to have passed such other examination as may from time to time be recognised for this purpose by the University.

The subjects of the Matriculation Examination are—1, Latin; 2, mathematics; 3, mechanics; 4, English and history; 5, one of the following:—(*a*) French; (*b*) German; (*c*) Greek; (*d*) Italian; (*e*) Spanish; (*f*) any other modern language, permission to present which has been obtained from the Joint Matriculation Board. Notice of intention to present either Italian or Spanish must be given to the Secretary, Joint Matriculation Board, Manchester, before March 1st in each year.

Before admission to the Degrees of Bachelor of Medicine and Surgery candidates are required to send in the usual certificates of age and study as at the other Universities. All candidates for these Degrees must pass four examinations, and must have attended courses of both lectures and laboratory work.

The final examination is divided into two parts, which may be passed separately or on the same occasion, but the first part cannot be taken before the end of the third year, and the second part cannot be taken less than two years after passing Second M.B., or before the fifth year of medical study in accordance with the University regulations. The subjects of examination are as follows: 1, Pharmacology and therapeutics; 2, General pathology and morbid anatomy; 3, Forensic medicine and toxicology and public health; 4, Obstetrics and diseases of women; 5, Surgery, systematic, clinical, and practical; 6, Medicine, systematic and clinical, including mental diseases and diseases of children. Candidates may select as a first part of the examination two or three of the subjects 1, 2, and 3.

The certificates required from candidates at the Third and Final examinations are practically the same as for the Final examination at the London University, and only those who have previously passed the Second Examination are admitted to it. The regulations relating to the M.D. and Ch.M. Degrees can be obtained on application to the Registrar.

Fees.—Matriculation examination, £2. First Examination, £5; for any subsequent examination, £2. The fees for the Second Examination, for the Third and Final Examinations, and for the examination for the degree of Ch.M. are the same as for the First Examination. A fee of £10 is payable on the conferring of the degree of M.D., a fee of £5 on the conferring of the degree of Ch.M.

The Matriculation Examination is held in July and in September. The first M.B. and Ch.B. is held in June; also about the end of September. The second examination is held in December, or in January or March; the Final in July and March; the examination for Ch.M. in July only.

The medical school buildings, which include large laboratories, dissecting-rooms, library and reading-rooms, are on the most modern principles, and students wishing to engage in anatomical, physiological, or pathological research will find excellent opportunity for study in the complete and well-furnished laboratories. Hospital practice is taken out at the (a) Royal Infirmary, which contains 300 beds. The Cheadle Lunatic Asylum, St. Mary's Hospital, the Southern Hospital, and other special hospitals also afford teaching facilities of great importance.

The appointments open to students are numerous and of considerable monetary value, and there are probably more here than are available at any other medical centre. The principal are:—Nine Entrance scholarships, the Leech fellowship of £100; Entrance scholarships in medicine, £100 (towards College and Infirmary fees); Manchester Grammar School scholarships, two or three of not less than £15 or more than £30 per annum for three years; Turner scholarship of £20 to students who have completed a course of medical study in the University; Platt physiological scholarships, two of the value of £50 each; Platt zoological and botanical scholarship, £50; Professor Tom Jones' memorial surgical scholarship of £100, awarded triennially; two Dauntsey medical entrance scholarships, value £35; John Henry Agnew scholarship in diseases of children, value £30, awarded annually; Graduate scholarship in medicine, £25 to £50, awarded annually; and many others.

Fees.—Composition fee, 83 guineas, in three instalments of 23, 30 and 30 guineas. Hospital practice: Composition fee, £42, or two instalments of £22 each.

Dental Fees.—Composition fee, £60, payable in two sums of £30 each. Hospital practice, £21.

UNIVERSITY OF BIRMINGHAM.

The University of Birmingham grants Degrees of M.B., Ch.B., M.D., Ch.M., and also a B.Sc. in the subject of Public Health. As a rule, in order to obtain any of these Degrees it is necessary that a student shall have passed at least the first four years of his curriculum in attendance upon the classes of the University, but the Senate has power of recognising attendance at another University as part of the attendance qualifying for these degrees.

Degrees of Bachelor of Medicine and Bachelor of Surgery.—The student must have passed either the Matriculation Examination of the University or one of the following examinations, which will be accepted in lieu thereof for the present:—(*a*) The previous examination of the University of Cambridge; (*b*) Responsions of the University of Oxford; (*c*) The matriculation examination of any other University in the United Kingdom; (*d*) The leaving certificate (higher) of the Oxford and Cambridge Boards; (*e*) The Oxford or Cambridge junior local examination (first or second class honours); (*f*) The Oxford or Cambridge senior local examination (honours).

Matriculation Examinations are held in June and September each year.

Degrees of Doctor of Medicine and Master of Surgery.—At the end of one year from the date of having passed the Final M.B., Ch.B. Examination, the candidate will be eligible to present himself for the higher Degrees of either Doctor of Medicine or Master of Surgery or both, the regulations for which may be had upon application to the Dean. The University also grants a Degree and a Diploma in Public Health, and provides adequate instructions for the same.

Dental Department.—The University grants the Degrees of Bachelor and Master of Dental Surgery (B.D.S. and M.D.S.), and a Diploma in Dental Surgery (L.D.S.). The whole of the instruction for which may be taken out in the University, with which is associated the Birmingham Dental Hospital.

The General and Queen's Hospitals.—The practices of these hospitals are amalgamated for the purpose of clinical instruction under the direction of the Birmingham Clinical Board, by whom all schedules will be signed and all examinations conducted. The hospitals have a total of upwards of 450 beds. 8,000 in-patients and 80,000 out-patients are treated annually, and many valuable posts are open to students at both.

Further information can be obtained from Professor Gilbert Barling, Dean, Medical Faculty.

THE UNIVERSITY OF LIVERPOOL.

The Degrees in the Faculty of Medicine are Bachelor of Medicine and Bachelor of Surgery (M.B. and Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). The course of study for the Degrees of Bachelor of Medicine and Bachelor of Surgery is of five years' duration, and of this period two years must be spent at the University, the remaining three years can be taken in any medical school approved by the University.

For the Degree of M.D., a thesis is required which may be presented not earlier than one year after graduation, as M.B., Ch.B.

The degree of Ch.M. is given after a period of at least one year of further study after graduation as M.B., Ch.B., on the results of an examination.

Diplomas.—Diplomas have been instituted in Public Health (D.P.H.), Tropical Medicine (D.T.M.), and Veterinary Hygiene (D.V.H.). Special diplomas are also granted in Anatomy, Bacteriology, Bio-chemistry, and Parasitology after a course of study of three terms in the subject chosen and allied subjects.

Students may enter for the degrees of the University of Liverpool, or may study for the degrees, diplomas and qualifications of the other licensing bodies.

Hospitals.—The Clinical School of the University now consists of four general hospitals—the Royal Infirmary, the David Lewis Northern Hospital, the Royal Southern Hospital, and the Stanley Hospital; and of five special hospitals—the Eye and Ear Infirmary, the Hospital for Women, the Infirmary for Children, St. Paul's Eye and Ear Hospital, and St. George's Hospital for Skin Diseases. These hospitals contain in all a total of 1,127 beds. The organisation of these hospitals to form one teaching institution provides the medical student and the medical practitioner with an unrivalled field for clinical education and study, and all are within easy access from the University. The period of hospital practice extends over the last three years of medical study. During the first two years no student will be permitted to change his attendance from one general hospital to another except at the commencement of an academic term. It is a regulation of the school that not more than five of the six terms of these two years shall be spent at any single General Hospital. During the final year of hospital practice a student is permitted to attend the practice of all the general hospitals without restriction. The regulations demand only that his attendance shall be regular and to the satisfaction of the Hospital's Board. There are a large number of appointments to House Physicianships and Surgeonships both at the general and special hospitals, which are open to qualified students of the School. These appointments (20) in most cases carry salaries varying from £60 to £100 per annum.

Fellowships and Scholarships.—Fellowships, Scholarships, and Prizes of over £800 are awarded annually. A Holt Fellowship in Pathology and Surgery, of the value of £100 for one year, is awarded annually by the Medical Faculty to a senior student possessing a medical qualification. The successful candidate is required to devote a year to tutorial work and investigation in the Pathological department. A Holt Fellowship in Physiology, awarded under similar conditions, also of the value of £100 for one year. A Robert Gee Fellowship in Anatomy, awarded under similar conditions, of the value of £100 for one year. An Alexander Fellowship for Research in Pathology of the annual value of £100, renewable. A Johnston Colonial Fellowship in Pathology and Bacteriology (£100 a year, renewable). A John W. Garrett

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(*a*) **A new Infirmary is in course of erection, within a few minutes' walk from the University, which, when complete in 1908, will contain all the latest improvements of modern times.**

International Fellowship in Physiology and Pathology (£100 a year, renewable). An Ethel Boyce Fellowship in Gynæcological Pathology (£100 a year, renewable). A Stopford Taylor Fellowship (£100 a year, renewable) in Dermatological Pathology. A Thelwall Thomas Fellowship (£100 a year, renewable) in Surgical Pathology. A scholarship in Surgical Pathology (£50 a year renewable). Two Lyon Jones scholarships, of the value of £21 each for two years, are awarded annually—a Junior Scholarship, open at the end of the first year of study to Liverpool University students in the subjects of the first M.B. Examinations, and a Senior Scholarship, open to all students in the school at the end of the second or third year of study, in the subjects of Anatomy, Physiology, and Therapeutics. The Derby Exhibition of £15 for one year is awarded in Clinical Medicine and Surgery in alternate years. Students may compete in their fourth and fifth years. In 1908 the subject will be Clinical Surgery. The Torr Gold Medal in Anatomy, the George Holt Medal in Physiology, the Kanthack Medal in Pathology, and the Robert Gee Book Prize, of the value of £5, for Children's Diseases.

Entrance Scholarships.—Two Robert Gee Entrance Scholarships, of the annual value each of £25 for two years, are offered annually for competition. The holder is required to take out the First M.B. Course for the University Degree in Medicine.

The University also grants a Diploma in Dental Surgery (L.D.S.) and Degrees in Dental Surgery (B.D.S. and M.D.S.) The courses of systematic instruction are given in the University buildings, five minutes walk from the Dental Hospital.

Communications should be addressed to the Dean, Professor Benjamin Moore, M.A., D.Sc., the University, Liverpool.

Liverpool School of Tropical Medicine, and Diploma of Tropical Medicine, University of Liverpool.—The school is affiliated with the University of Liverpool and the Royal Southern Hospital of Liverpool. Three courses of instruction are given every year, commencing on January 14th, May 1st, and October 1st, and lasting for the academical term of about ten weeks. Each Course consists (1) of a systematic series of lectures on tropical medicine and sanitation delivered by the Professor of Tropical Medicine at the University; (2) of additional lectures on cytology, special African diseases and special Indian diseases delivered at the University; (3) of systematic lectures and demonstrations on tropical pathology, parasitology and bacteriology by the Walter Myers lecturer, at the University; (4) of similar instruction on medical entomology by the Lecturer on economic entomology at the University; and (5) of clinical lectures and demonstrations delivered at the Royal Southern Hospital by the Physician in charge of the Tropical Ward, the Professor, and the Walter Myers Lecturer. The instruction given occupies six hours a day for five days a week during the term. Teaching under headings 3 and 4 above is delivered in the Laboratory of the school at the University, which contains accommodation for thirty students with all necessary appurtenances, including a well-equipped museum, a class library, and access to the general departmental library. Teaching under heading 5 is given in the Tropical Ward, and the attached clinical laboratories of the Royal Southern Hospital on two or three afternoons a week.

At the end of each term an examination is held by the University for its Diploma of Tropical Medicine (D.T.M.), which is open only to those who have been through the course of instruction of the school. The examination lasts three days, and consists (1) of three papers on tropical medicine, tropical pathology, and tropical sanitation and entomology respectively; (2) of a clinical examination; and (3) of an oral examination. The results are declared as soon as possible afterwards. Those who do not wish to undertake the examination are given a certificate of attendance if their attendance has been satisfactory.

Accommodation for a limited number of students may be had at the Hall of Residence (for terms, apply to the Warden, 44 Upper Parliament Street).

The fee for the full course of instruction is ten guineas, with an extra charge of ten shillings for the use of a microscope, if required. The fee for the examination is five guineas. Applications should be made to the Dean of the Medical Faculty, University of Liverpool, from whom prospectuses may be obtained.

Two University Fellowships of £100 a year each are open to students of the school, amongst others. Accommodation for Research work is to be had, both at the University laboratory of the school, and at its Research Laboratories at Runcorn (sixteen miles distant from Liverpool).

Since it was instituted nine years ago the school has employed twenty-five different investigators paid out of its funds, and has despatched to the tropics seventeen scientific expeditions, many of the workers having been taken from among its students. The work done by them has been published in twenty-one special memoirs with many plates and figures, besides text books and numerous articles in the scientific press. From the beginning of this year, however, the Memoirs have been succeeded by the Annals of Tropical Medicine and Parasitology, published by the Committee, and open to outside contributors (apply to the Secretary, B10, Exchange Buildings, Liverpool). The Mary Kingsley Medal is awarded by the School for distinguished work in connection with tropical medicine, and has been given to Colonel Bruce, Professor Koch, Dr. Laveran and Sir Patrick Manson.

UNIVERSITY OF BRISTOL.

The lectures and instruction given in the Faculty of Arts and Science of University College, Bristol, are adapted to the various preliminary science examinations, and students can complete in Bristol the entire course of study required for the medical and surgical degrees of the University of London and the Royal College of Surgeons of England, and of the Apothecaries' Society of London. Well-equipped laboratories are now provided for anatomy, physiology, bacteriology, and pathology. Students of the college are admitted to the clinical practice of those very important and well-equipped institutions, the Bristol Royal Infirmary and the Bristol General Hospital. The infirmary and the hospital comprise between them a total of 470 beds, and both have very extensive out-patient departments, and special departments for the diseases of women and children, and of the eye, ear, and throat, besides large outdoor maternity departments and dental departments. Students of the college also have the privilege of attending the practice of the Bristol Royal Hospital for Sick Children and Women, containing 104 beds, and that of the Bristol Eye Hospital, with 40 beds. The total number of beds available for clinical instruction is therefore 614. Very exceptional facilities are thus offered to students for obtaining a wide and thorough acquaintance with all branches of medical and surgical work, and the whole curriculum is now open to women as well as men.

Appointments.—At the Royal Infirmary, and also at the General Hospital, clinical clerks and dressers reside in the house in weekly rotation. A pathological clerk is appointed every three months. Also obstetric clerks and ophthalmic dressers. Clinical lectures are given regularly at both institutions.

Scholarships, Prizes, &c.—Prizes and certificates of honour are given in University College in all the subjects of the curriculum. There are one medical entrance scholarship, value £75, awarded annually, two Martyn memorial scholarships (pathology and morbid anatomy) of £10 each, the Tibbits memorial prize, value £9, for proficiency in practical surgery, Henry Marshal prize, £12; Clarke Scholarship, £15; Sanders Scholarship, £22 10s.; one gold and silver medal awarded by the committee, and various prizes for clinical work in surgery and medicine.

Fees.—School fees for attendance on all courses of lectures and hospital practice, and including all fees, except vaccination and small charge for board of midwifery student, 133 guineas. If in two instalments, 80 guineas at first session and 60 guineas in the beginning of the second year. Dental composition fee, 75 guineas, including all lectures, practical classes, and hospital practice. Dental mechanical laboratory fee, 75 guineas. Clinical fees (if the composition fee has not been paid)—Surgical practice, one year, 12 guineas; perpetual, 20 guineas. Medical practice, 20 guineas; perpetual, medicine and surgery, 40 guineas.

Prospectus and further information on application to the Dean, Professor Edward Fawcett, M.D.

UNIVERSITY OF LEEDS.

The school of medicine attached to this recently incorporated University, was originally founded more than seventy years ago as the Leeds Medical School. The building, erected on a site contiguous to the infirmary, and opened twelve years since, contains one of the finest dissecting rooms in the Kingdom, extensive laboratories for physiology and pathology with the most recent improvements in fittings and apparatus, ample lecture-room accommodation, a large library, and separate museums for pathology and anatomy. Professors and lecturers are attached, and the clinical teaching is given by the physicians and surgeons attached to the Leeds General Infirmary, one of the largest in the United Kingdom, having 524 beds, with a staff of physicians and surgeons of considerable eminence. Ophthalmic demonstrations and demonstrations of skin diseases are given in the infirmary by surgeons in each department, where also are obtainable various clinical clerkships, dresserships, and other appointments; and an extern maternity charity is attached, at which the necessary attendance at labours can be taken, Besides the infirmary there is a large dispensary, a large hospital for infectious diseases, a hospital for women and children, and a maternity home, all of which are open to students of the school.

Scholarships, Prizes, &c.—(1) An entrance scholarship of £73 2s. 6d. There is also a Hardwick prize in clinical medicine, a M'Gill prize in clinical surgery, each of the value of £10. Thorp prizes of £10 and £5 in forensic medicine and hygiene, and a Scattergood prize of £5 in midwifery, besides silver and gold medals and other class prizes. The composition fee for attendance upon all the required courses of school lectures is £73 2s. 6d. for University students who have attended the preliminary scientific courses, and the same for non-University students, exclusive of chemistry and biology.

At the General Infirmary, the composition fee for medical and surgical practice and clinical lectures is £42 in one sum, or two instalments of £22 each. These fees are not included in the composition fees for lectures and are payable separately.

A scholarship of £42 to cover the cost of medical and surgical practice is offered annually by the Infirmary.

Degrees and Diploma in Dental Surgery are obtainable at this University, being Bachelor of Dental Surgery (B.Ch.D.), and Master of Dental Surgery (M.Ch.D.). Candidates for the degree of Bachelor of Dental Surgery are required to have passed the Matriculation Examination, to have pursued thereafter approved courses of study for not less than five academic years, two of such years at least having been passed in the University subsequently to the date of passing Parts I. and II. of the first examination, and to have completed such period of pupilage or hospital attendance, or both, as may be prescribed by the Regulations of the University. No candidate shall be admitted to the degree who has not attained the age of twenty-one years on the day of graduation.

Candidates for the diploma in Dental Surgery are required to present certificates showing that they have attained the age of twenty-one years, that they have attended courses of instruction, approved by the University, extending over not less than four years and that they have completed a pupilage of three years, two of such years at least, having been taken before the First Professional examination. Candidates are required to satisfy the Examiners in the several subjects of the following examinations: A preliminary examination in Arts; a Preliminary examination in Science; the First Professional examination; and the Final examination.

UNIVERSITY OF WALES.

The Cardiff School of Medicine, which is one of the colleges of the University of Wales, has since its foundation, in 1883, prepared students for the Preliminary Scientific Examination of the University of London, and for the corresponding examinations of other licensing bodies. In 1893 Chairs of Anatomy and Physiology and a Lectureship in Materia Medica and Pharmacy were established, making it possible for students of medicine to spend three out of the five years of prescribed study at Cardiff. Arrangements with the managing committee of the Cardiff Infirmary give students of the College the privilege of attending this large and well-ordered hospital, which is situated within five minutes' walk of University College. Many students, especially from Wales and Monmouthshire, avail themselves of the opportunities thus afforded to pursue the earlier part of the medical curriculum near home. All classes are open alike to both men and women students over sixteen years of age. The courses of instruction given at Cardiff are recognised as qualifying for the examinations of the Universities, Royal colleges, and other licensing bodies of Great Britain and Ireland. Having spent two or three years in study at Cardiff, and having passed the examinations in these years, a student may proceed to London or elsewhere and complete his qualifying course for a University degree or for a college diploma.

Students preparing for the first and second examinations of the Conjoint Board for England, or for the corresponding examinations of the Conjoint Board for Scotland, or for those of the Society of Apothecaries, may compound for their classes by paying a single composition fee of £41 10s., or by paying £20 and £24 10s. at the beginning of their first and second years respectively. Those preparing for the preliminary scientific and intermediate examination in medicine of the University of London may compound for their three years' instruction at Cardiff by paying a single composition fee of £57 10s., or by paying £13 13s., £28, and £21 at the beginning of their first, second and third years respectively.

In 1899 a department of Public Health was established, and lecturers in bacteriology and in public health and hygiene were appointed. Medical men preparing for a diploma in Public Health and Hygiene can attend complete courses of lectures and laboratory instruction in this department. These courses are recognised by the University of Cambridge, by the Royal Colleges of Physicians and Surgeons, and by Victoria University.

In the case of medical students, attendance on the class of hygiene and public health is accepted by the Universities of London and Cambridge, and by the Conjoint Examining Board of England

Courses of lectures to midwives, adapted to the requirements of the Central Midwives' Board, under the Midwives Act, are commenced in October, January, and April. The lectures are suitable both for pupil midwives and practising midwives, as well as for nurses who desire to enter for the examination for certification under the Act.

Scholarships, &c.—The attention of students about to matriculate is drawn to the numerous entrance scholarships and exhibitions which are offered at the college for competition in September, most of which may be held by medical students. Full particulars of the examination for these may be obtained from the Registrar, or from the Dean of the Medical Faculty.

UNIVERSITY OF SHEFFIELD.

By the Charter granted in 1905, this University is permitted to grant degrees in medicine. All its courses and all its degrees are open, without restriction, to both sexes. The new buildings of the University, opened by his Majesty King Edward in 1905, are situated at the west end of the city, overlooking on two sides the adjoining Weston Park. The medical department occupies the entire north wing of the University quadrangle, and is within easy reach of the various hospitals, with which it is connected for clinical purposes.

These are as follows:—The Royal Infirmary contains 255 beds, with an annual average number of over 3,800 in-patients, over 8,000 out-patients, and over 21,000 casualties; the Royal Hospital, with 165 beds, and an annual number of 2,500 in-patients, over 7,000 out-patients, and over 14,000 casualties; the Jessop Hospital for Diseases of Women, with 80 beds, nearly 500 in-patients, and over 2,000 out-patients; also a Maternity Department, with over 250 in-patients per annum, and over 700 out-patient cases attended. Special courses on fevers are held at the City Fever Hospitals (547 beds), and on Mental Diseases at the South Yorkshire Asylum (1,610 beds).

Clinical Practice.—The practices of the Royal Infirmary and Royal Hospital are amalgamated for the purpose of clinical instruction, giving a total of 420 beds for the treatment of medical, surgical and special cases.

Appointments.—The following are open to all students who have passed their examinations in anatomy and physiology:—Casualty Dresserships, Surgical Dresserships, Medical Clerkships, Pathological Clerkships, Ophthalmic Clerkships, Clerk to the Skin Department, etc.

Fees.—Composition fee of £80, payable in three instalments, viz.:—£24 at commencement of first year of study; £28 at commencement of second year of study; £28 at commencement of third year of study. This composition fee entitles the student to attendance on all the courses of lectures and practical classes, except pharmacy, vaccination, and instruction in anæsthetics required for a degree course in the University, or for the ordinary qualifications in medicine and surgery of the examining boards.

Composition Fee for Medical and Surgical Hospital Practice.—Fee for the full period of both medical and surgical hospital practice required by the examining boards:—If paid in one sum at commencement of hospital practice, £36 15s.; or if paid in two sums of £18 18s., one on beginning hospital practice, the other twelve months later, £37 16s.

Dental Department.—In connection with the University there is a complete dental department, which is fully recognised by the various examining bodies, and students are able to get their full curriculum here.

Scholarships and Fellowships.—Women's Medical Scholarship, value £100, open to women only; awarded in September, 1907. Entrance Medical Scholarship, value £116, open to both sexes, awarded in June in each year. Two Staff Medical Scholarships, each value £50; open to both sexes. One Town Trustees' Scholarship, value £50, tenable for three years, for girls under the age of 19 years. Two Town Trustees' Scholarships, value £60 each, for boys or girls under 19 years of age. Town Trustees' Fellowship, value £75, open to graduates of the University, tenable for one year. Mechanics' Institute Scholarship, value £50, tenable for one year, and renewable for a second year. The Frederick Clifford Scholarship, value about £50 per annum, tenable for two years, open to graduates of the University; and the Kaye Scholarship, value about £22 10s. Gold Medal offered annually for the best student in clinical medicine and clinical surgery. Bronze medals are awarded each year to the students who have gained first place in the examinations for the full course.

Degrees.—Candidates for a medical degree must have matriculated in the University or have passed such other examination as may be recognised for this purpose by the University and sanctioned by the Joint Matriculation Board. The subjects required by the General Medical Council must be included in the matriculation examination, or its recognised substitute. The degrees in medicine obtainable are Bachelor of Medicine and Bachelor of Surgery (M.B., Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.); conditions and particulars of which may be obtained on application to the Dean.

At the University of Sheffield post-graduate courses are held annually. The subjects vary from time to time, and include bacteriology, physiology, applied anatomy, surgery, operative surgery, ophthalmic surgery, diseases of ear and throat, dermatology, etc.

THE ENGLISH COLLEGES.

THE medical corporations in England are the Roya College of Physicians of London, the Royal College of Surgeons of England, and the Society of Apothecaries of London. The two Royal Colleges now co-operate to hold a series of examinations, on passing which the candidate receives the diploma of Licentiate of the Royal College of Physicians (L.R.C.P.), and Member of the Royal College of Surgeons (M.R.C.S.). The Society of Apothecaries grants a complete diploma (L.S.A.) in medicine, surgery, and midwifery.

CONJOINT EXAMINING BOARD IN ENGLAND.

Candidates for the above licences are required to complete five years of professional study at recognised medical schools and hospitals, after passing the preliminary examination, of which six months may be spent at an institution recognised by the Board for instruction in chemistry, or one year may be passed at an institution recognised by the Board for instruction in chemistry and physics, to comply with the following regulations and to pass the examinations hereinafter set forth.

Professional Examinations.—There are three examinations, each being partly written, partly oral, and partly practical. These examinations will be held in the months of January, April, July, and October, unless otherwise appointed, fourteen clear days' notice before the day on which the examination commences being required, the candidate transmitting at the same time the required certificates.

The subjects of the first professional examination are chemistry and physics, practical pharmacy, and elementary biology. A candidate is allowed to take this examination in three parts at different times. Rejection entails a delay of not less than three months from the date of rejection, and the candidate will be re-examined in the subject or subjects in which he has been rejected. If referred in chemistry or biology, he must produce evidence of further instruction at a recognised institution. Practical pharmacy may be passed at any time during the curriculum. Any candidate who shall produce satisfactory evidence of having passed an examination for a degree in medicine on any of the subjects of this examination conducted at a University in the United Kingdom, India, or in a British Colony, will be exempt from examination in those subjects in which he has passed.

The fees for admission to the first examination are as follow:—For the whole examination, £10 10s.; for re-examination after rejection in Part I., £3 3s.; and for re-examination in each of the other parts, £2 2s.

The subjects of the second examination are anatomy and physiology. Candidates will be required to pass in both subjects at one and the same time. Candidates will be admissible to the second examination at the expiration of two winter sessions and one summer session (or fifteen months during the ordinary sessions) from the date of registration as medical students, and after the lapse of not less than nine months from the date of passing Parts I. and III. of the first examination.

A candidate referred at the second examination will be required, before being admitted to re-examination, to produce a certificate that he has pursued, to the satisfaction of his teachers, in a recognised place of study, his anatomical and physiological studies during a period of not less than three months subsequently to the date of his reference.

The fees for admission to the second examinations are: £10 10s. for the whole examination, and £6 6s. for re-examination after rejection.

The subjects of the third and final examinations are:—Part I. Medicine, including medical anatomy, pathology, practical pharmacy, therapeutics, forensic medicine and public health. Candidates who have passed in practical pharmacy at the first examination will not be re-examined in that subject at the third examination. Part II. Surgery, including pathology, surgical anatomy, and the use of surgical appliances.

Part III. Midwifery and gynæcology. Candidates may take this examination in three parts separately, or they may present themselves for the whole examination at one time.

Fees for admission to the third or final examination are as follow:—For the whole examination, £21 0s. Part I.—For re-examination in medicine, including medical anatomy, pathology, therapeutics, forensic medicine, and public health, £5 5s.; for re-examination in practical pharmacy (if taken at this examination), £2 2s. Part II.—For re-examination in surgery, including pathology, surgical anatomy, and the use of surgical appliances, £5 5s. Part III.—For re-examination in midwifery and gynæcology, £3 3s.

A candidate referred on the third or final examination will not be admitted to re-examination until after the lapse of a period of not less than three months from the date of rejection, and will be required, before being admitted to re-examination, to produce a certificate, in regard to medicine and surgery, of having attended the medical and surgical practice, or the medical or surgical practice, as the case may be, during the period of his reference; and in regard to midwifery and diseases peculiar to women a certificate of having received, subsequently to the date of his reference, not less than three months' instruction in that subject by a recognised teacher.

Regulations for Colonial, Indian, and Foreign Candidates, and University Candidates.

Persons holding a Colonial, Indian, or a foreign qualification entitling them to practise medicine in the country of origin, and conferred after a course of study and examinations equivalent to those required by the Royal Colleges, are admissible to the second and third (final) examinations forthwith.

Members of a University in the United Kingdom are, under certain conditions, eligible for admission to the third (final) examination two years after passing at their University in the subjects included in the first and second examinations of the Board.

Royal College of Physicians of London.

Members.—The membership of the College is granted after examination to persons above the age of 25 years who do not engage in trade, do not dispense medicine, and do not practise in partnership. This diploma is only granted to persons already registered, or who have passed the final examination for the licence.

Medical graduates of a recognised University are admitted to a pass examination, but others must have passed the examinations required for the licence of the College. The examination, which is held in January, April, July, and October, is partly written and partly oral. It is directed to medicine, and is conducted by the president and censors. Candidates under 40, unless they have obtained a degree in arts in a British University, are examined in Latin, and either Greek, French, or German. Candidates over 40 are not so examined, and the examination in medicine may in their case be modified under conditions to be ascertained by application to the Registrar. The fee for the membership is £42, but if the candidate is a licentiate £15 5s. is deducted. In either case £6 6s. has to be paid before examination.

Royal College of Surgeons of England.

Membership.—The candidates are now subject to the regulations of the Conjoint Board.

Fellowship.—The Fellowship of the College of Surgeons is granted after examination to persons at least 25 years of age, who have been engaged in professional studies for six years. There are two examinations—the first in anatomy and physiology, which may be passed after the third winter session; the second chiefly directed to surgery, which may be passed after six years of professional study. The second examination may be passed before attaining the age of 25, but the diploma is not granted until that age is reached. Candidates for this part of the examination must have passed the final examination of the Conjoint Board in England, and have been admitted members of the College before they can be admitted thereto, except in the case of graduates in medicine and surgery of recognised Universities of not less than four years' standing.

Fees.—First examination, £5 5s.; second examination, £12 12s. The total fee payable on admission to the Fellowship is £31 10s., except for members, when the fee is £21. (The examination fees to the extent of £17 17s. count as part of the total fee.) Further information can be obtained on application to the Secretary of the Royal College of Surgeons, Lincoln's Inn Fields, London, W.C.

There are two examinations—primary and final. The primary examination is held quarterly on the first Wednesday, and on the Monday and Tuesday in the same week, in the months of January, April, July, and October. The final examination is held monthly.

Society of Apothecaries of London.

Primary Examination.—This examination consists of two parts: Part I.—Elementary biology, Chemistry, Chemical physics, including the elementary mechanics of solids and fluids; Heat, Light, and Electricity. Practical chemistry, Materia medica, and Pharmacy. A synopsis indicating the range of the subjects may be obtained on application. Part II.—Anatomy and Physiology and Histology. The examination is held in January, April, July, and October.

The final examination is held monthly, and is divided into Sections 1 and 2.

Section 1 consists of three parts.

Part I. includes: Principles and Practice of Surgery, Surgical Pathology, and Surgical Anatomy, Operative Manipulations, Instruments and Appliances.

Part II. includes: (*a*) The Principles and Practice of Medicine, including Therapeutics, Pharmacology, Pathology, and Morbid Histology. (*b*) Forensic Medicine, Hygiene, Theory and Practice of Vaccination; and Mental Diseases.

Candidates passing either (*a*) or (*b*) will not be re-examined therein.

Part III. includes: Midwifery, Gynæcology, and Diseases of New-born Children, Obstetric Instruments and Appliances. Candidates may enter for Parts I., II., and III. together or separately.

Section 1 of the Final Examination, or any part thereof, cannot be passed before the expiration of 45 months from the date of registration as a medical student.

Section 2.—This section consists of two parts:

Part I.—Clinical Surgery.

Part II.—Clinical Medicine and Medical Anatomy. Section 2 cannot be passed before the expiration of the fifth year.

Fees.—Primary examination, £5 5s.; final examination, £15 15s.; total fee, £21.

Further information, with particulars as to the course of study and of the certificates required, can be obtained from the Secretary to the Court of Examiners, Apothecaries' Hall, E.C.

This licence is a registrable diploma in Medicine, Surgery, and Midwifery, and qualifies the holder to compete for medical appointments in the Army, Navy, and Indian Services, also for Poor-law, Civil, and Colonial appointments.

The Gillson scholarship in Pathology of the annual value of £90, tenable for one year, is open to Licentiates of the Society and to candidates for the diploma who obtain it within six months of election to the scholarship. An examination in the art of prescribing is held annually, in January, at which the following prizes are awarded:—A gold medal of the value of £6; a silver medal, and a prize of books to the two best candidates.

LONDON SCHOOLS.

The Schools of Medicine in the Metropolis are the following, the scholarships, prizes, students' appointments, fees, &c., being set forth in connection with each place named. The names of the hospital staff, lecturers, residential terms, and detailed information will be found, as a rule, in our advertisement columns.

St. Bartholomew's Hospital.—This hospital has 750 beds, and for many years past the school attached has had a larger number of students than any other medical school in London. Laboratories have been specially equipped for the study of pathology, bacteriology, chemistry, biology, physics, and chemical pathology, and two additional operation theatres have just been built. A new block of buildings has just been completed at a cost of £120,000, and contains new casualty and out-patients' departments, eight special departments, quarters for the junior staff, a dining hall and a common-room for students, &c. Collegiate residence is permissible, subject to the ordinary rules.

Appointments.—Ten house physicians and ten house surgeons are appointed annually. During the first six months of office they act as "junior" house physicians and house surgeons, and receive a salary of £25 a year. During their second six months they become "senior" house physicians and house surgeons, and are provided with rooms by the hospital authorities, and receive a salary of £80 a year. A resident midwifery assistant and an ophthalmic house surgeon are appointed every six months, and are provided with rooms and receive a salary of £80 a year. Two assistant anæsthetists are appointed annually, and receive salaries of £120 and £100 a year respectively. An extern midwifery assistant is appointed every three months, and receives a salary of £80 a year. Chief assistants and clinical assistants are appointed in each of the special departments. In-patient dressers, in-patient clinical clerks, clerks, and dressers to the assistant physicians, and assistant surgeons, and to the physicians and surgeons in charge of special departments, are appointed every three months without fee.

Scholarships, &c.—There are four open scholarships in science, £75, £75, £150, £50, tenable for one year, and an Entrance Scholarship in Arts, value £100, and the Jeaffreson exhibition, value £20; at the end of first year four junior scholarships of £30, £20, £25, £15, respectively; Treasurer's prize for practical anatomy; Foster prize in practical anatomy; senior scholarship, value £50, for anatomy, physiology, and chemistry; Wix prize, Hichens prize, Lawrence scholarship and gold medal, value 40 guineas, for medicine, surgery, and midwifery; two Brackenbury scholarships, of £39, in medicine and surgery; Bentley prize, for reports of cases; the Kirkes gold medal for clinical medicine, with scholarship of £30. Shuter scholarship of £50; Skynner prize of £15; Sir G. Burrows' prize of £10; Matthews Duncan prize, medal and about £20; Willett medal and Walsham prize; Holden Research Scholarship in Surgery, value £105.

Composition Fees.—(1) For students commencing their medical studies, one sum on entrance, 165 guineas; or by four instalments of 45 guineas. (2) For students who have passed an examination in preliminary science, in one sum on entrance, 145 guineas; or by instalments. (3) For students who have finished two years of medical study but have not passed an examination completing their anatomical and physiological studies; if paid in one sum on entrance, 110 guineas; or by annual instalments. (4) For students who have completed three years of medical study but have not passed an examination in anatomy and physiology; 90 guineas; or by annual instalments. (5) University students who have passed an examination completing their anatomical and physiological studies, in one sum, 80 guineas; or by instalments.

Fees for preliminary scientific students:—20 guineas; for laboratory instruction for D.P.H., 15 guineas. Fuller details will be supplied on application to the Dean.

Charing Cross Hospital.—The school attached to this hospital is situated in Central London, and contains new physiological, pathological, and bacteriological laboratories, materia medica and anatomical museums, an anatomical theatre, enlarged dissecting-rooms, and chemical theatre. Clinical instruction is given in medicine, surgery, and obstetrics, and in the special department, diseases of the skin, diseases of children, mental disorders, the throat, the eye, nose and ear, and in the orthopædic, Röntgen and electrical departments.

The school is complete in all departments, with special teachers for all preliminary and intermediate subjects.

Entrance Scholarships are awarded annually to the value of £575.

Appointments.—The curator and pathologist are appointed annually at £100 a year each. Medical and surgical and obstetric registrars (annual) £40 a year each with luncheon in the hospital. Six house physicians, six house surgeons, and two resident obstetric officers are appointed each year, after competitive examinations. They are provided with board and residence in the hospital.

Fees.—The fees for the five years' curriculum may be paid either by composition fee, payable in one sum, on joining, 115 guineas, or by sessional payment system—Entrance fee, 10 guineas. In addition a sum of 15 guineas must be paid at the beginning of every winter session, and one of 10 guineas at the beginning of every summer session so long as the student remains in the school. Payment may also be made for individual classes and hospital practice when taken separately. Students of any university in the United Kingdom who have passed the examinations in anatomy, physiology, chemistry, and other preliminary subjects, may here complete their studies (except vaccination and attendance at a fever hospital) on payment of a fee of 74 guineas in one sum, or of 80 guineas in two sums, viz., one of 43 guineas on entry, and one of 37 guineas a year later.

The fees for dental students for the two years' curriculum may be paid:—(*a*) in one sum of 55 guineas on entry; (*b*) in two instalments—one of 31 guineas on entry; and the second of 30 guineas at the end of the first twelve months.

Prospectus and further information can be obtained on application to the Dean.

St. George's Hospital.—This hospital is situated in the West End, facing Hyde Park. It contains 351 beds, and special wards for ophthalmic cases and diseases of women.

Appointments.—Eight house physicians and eight house surgeons, entitled to reside and board in the hospital free of expense; twelve general assistants, six assistants in the special departments. Candidates for the above offices are selected quarterly by competition from among the perpetual pupils, sixteen pupils being in office at any one time. Obstetric assistant with a yearly salary at the rate of £50 and board and residence in the hospital; curator of the museum with a salary of £200; assistant curator with a salary of £100; a medical registrar, with a salary of £200 per annum; a surgical registrar with a salary of £200 per annum; an administrator of anæsthetics with a salary of £50 and two with salaries of £30 per annum. All offices are open to candidates without additional fee.

By arrangement with the University of London, all students for the first, second, and third years of the curriculum carry out the necessary courses of instruction at either King's College or University College. The entire teaching of the school is devoted to clinical subjects.

There are two scholarships open to University students, particulars of which will be furnished by the Dean.

Fees.—For first year, £21 or £26 5s., according to the course. For second and third years, £57 15s. in one sum or £63 in two instalments. Students entering their names on the books before commencing this preliminary or intermediate subjects pay no entrance fee. Entrance fee, 10 guineas; annual composition fee, 30 guineas.

Guy's Hospital.—This hospital is situated on the Surrey side of London Bridge, and contains 602 beds in constant occupation. There are special wards for ophthalmic and obstetric cases, eight beds in the latter being appropriated for difficult cases of labour. Some beds have also been set apart for diseases of the ear and throat, and an "isolation" ward for cases of infectious diseases arising in the hospital has been constructed. An obstetric registrar and tutor and two clinical assistants and registrars in the ophthalmic department are appointed to augment the teaching in the special departments, in addition to those attached to the general surgical and medical wards. Attached to the hospital is a large residential college with rooms for about sixty men, whilst for students who prefer to live in the suburbs, no other hospital is so conveniently placed, the railway accommodation being good and close at hand. There is a complete School of Dental Surgery at this Institution, which is recognised by the Royal College of Surgeons of England; the facilities thus afforded of completing the whole course of dental study including the pupilage in mechanical dentistry within the walls of one hospital will be appreciated by those intending to practise dentistry. A new museum for pathological specimens and additional lecture and class rooms were opened in 1906.

Appointments.—Eight house surgeons, eight house physicians, eight assistant house physicians, sixteen out-patient officers, sixteen assistant house surgeons, eight obstetric residents, two ophthalmic house surgeons, twenty-four clinical assistants, and ninety-six dressers are selected annually from the students according to merit, and without payment. There are also a large number of junior appointments, every part of the hospital practice being systematically employed for instruction.

Scholarships.—Open scholarships of £100 and £50 in classics, mathematics, and modern languages. Open scholarships of £150 and £60 in chemistry, physics, and biology, and an open scholarship of £50 for University students in two of the following subjects:—Anatomy, physiology, organic chemistry, zoology, physics. The following are the scholarships, prizes, and medals open to students of the hospital:—Junior prizes for general proficiency, £20, £15, £10; Hilton prize for dissection, £5; Michael Harris prize for anatomy, £10; Sands Cox scholarship for physiology, £15; Wooldridge prize for physiology, £10; Beaney prize in pathology, £34; Golding-Bird prize in bacteriology, gold medal and £20; Treasurer's gold medal in clinical medicine; Treasurer's gold medal in clinical surgery; Beaney studentship in materia medica (tenable for 3 years), annually £31 10s.; Gull studentship in pathology (tenable for 3 or 5 years), annually £150. The Arthur Durham travelling scholarship of the value of £100, triennially.

Fees.—A new system for payment of composition fees has been instituted at this school. Particulars may be obtained on application to the Dean, Guy's Hospital, London Bridge, S.E.

King's College Hospital.—This hospital is centrally situated, being contiguous to the Royal College of Surgeons, Lincoln's Inn Fields. The College adjoins Somerset House and is close to the hospital, in which there are 220 beds available for clinical teaching; ophthalmic, ear, throat, skin, and dental departments are attached to the hospital. Some wards are specially devoted to children's diseases. The wards have been refloored and the electric light is installed throughout.

Scholarships.—Two scholarships of the value of £100 each; a scholarship, value £50, is open to students of a British University who come up to London to complete their curriculum; and one of £40 for fifth year students. In addition, students may compete for the Carter, Todd, Tanner prizes, and all class and clinical prizes.

Appointments.—Medical and surgical Sambrooke registrarships, tenable for two years, each £50 per annum. Resident hospital appointments, *viz.*, senior and junior house physicians, assistant house physician, physician accoucheur's assistant and assistant house accoucheur, and three house surgeons with free board and residence at the hospital; and senior and junior clinical assistants in special departments.

Special courses of lectures and practical instruction in the chemical, physical, physiological, and other laboratories have been arranged for students preparing for preliminary scientific, intermediate, M.B., and other examinations of the University of London.

F.R.C.S. Examinations.—Special classes are arranged for the final F.R.C.S. examinations. Further particulars can be obtained from the Dean.

The London Hospital.—This hospital is the largest in Great Britain, containing, as it does, 914 beds. It has, moreover wards and a teaching staff for almost every special department in the domain of medicine; the scholarships and prizes are many and valuable.

The additional buildings for the department of public health, for the biological, chemical, and physical laboratories, materia medica museum, vaccinotherapy, &c., and the new bacteriological department with general laboratory, research laboratories and class rooms for D.P.H. work are now open.

Appointments.—The "House" appointments, which are numerous, are made without fee of any kind, and all resident officers are provided with free board and rooms, and in some instances with salary also.

Fees.—Perpetual fee for lectures, demonstrations and hospital practice, payable in three instalments of 45, 45, and 40 guineas at the commencement of the first, second, and third years respectively, 130 guineas; or, if in one payment, 120 guineas. Fee for students entering in their third year (their first and second years having been spent at a recognised medical school, elsewhere) 60 guineas. This fee is payable by students entering who have passed the first M.B. Oxford; the second M.B. Cambridge; or the Intermediate M.B. London. Dental students (general hospital practice and lectures), 40 guineas. General fee for dental practice, 10 guineas.

Note.—A reduction of 15 guineas will be allowed to the sons of medical men from the perpetual fee if paid in full, or 5 guineas from each instalment.

Special entries can be made either for single courses of lectures or for hospital practice. Residential accommodation is obtainable at a very reasonable rate close by, or in the suburbs a few minutes' distant by train. Fuller particulars can be obtained of the Warden, Mr. Munro Scott.

St. Mary's Hospital.—This hospital is situated at Paddington, near the terminus of the Great Western Railway, and at present contains 281 beds. The new wing, the ground-floor of which, comprising the new out-patient department, was opened in 1898, is now completed, and will be opened as soon as funds will permit; this will raise the number of beds to 350, and provide additional operating theatres. The Inoculation Department, instituted in 1906, has greatly expanded, and has been transferred to a series of rooms in the New Wing of the hospital.

The Department is under the personal supervision of Sir Almroth Wright, F.R.S.

The Athletic Ground (eight acres) is situated at North Kensington, and is easy of access from the Hospital.

Appointments.—All clinical appointments in the hospital are free to students of the Medical School, and the resident medical officers are chosen by competitive examination. Six house physicians, six house surgeons, four obstetric officers, and two resident anæsthetists are appointed in each year, and receive board and residence in the Hospital.

Scholarships, &c.—One scholarship in natural science, of the value of £145, open to any gentleman who has not completed a winter session of study at a medical school. One scholarship in natural science, of the value of £78 15s., and two of £52 10s., under the same conditions. Two scholarships, each of 60 guineas, open to students from any British University. The scholarships will be awarded by examination on September 23rd, 24th, and 27th.

Fees.—Fee for attendance on the full five years' curriculum of hospital practice and all lectures, demonstrations, and special tutorial classes, £140, paid in one sum on entering the school; or in instalments, £145.

Students who have completed their examinations in anatomy and physiology at the Universities of Oxford, Cambridge, or other University, are admitted as perpetual pupils on payment of a fee of 60 guineas in one sum, or 65 guineas in two annual instalments. University students, prior to completing the anatomy and physiology examinations, pay an annual fee of 25 guineas. After completing the anatomy and physiology examinations, the inclusive fee may be paid.

Preliminary Scientific Course.—A complete course of instruction in chemistry, physics, and biology, recognised by the University of London as an approved course for internal students, is held throughout the year. Students may join in October, January, or April.

MIDDLESEX HOSPITAL.—This hospital, which is conveniently situated in the centre both of business and residential London, contains 340 beds. There are special departments for cancer, and for ophthalmic, throat, aural, skin, dental, children's diseases, and electrical treatment (X-ray and Finsen light). Wards are also devoted to cases of uterine disease. Residence for students is obtainable in the residential college, which has its frontage on the hospital garden.

A Bacteriological and Public Health Laboratory has been added for the purpose of providing instruction for women medical practitioners preparing for the examinations for the Diploma in Public Health and for the M.D. in State Medicine of the University of London, and of affording facilities to them and other women students desirous of carrying out Research Work in Public Health, Bacteriology, and General Pathology.

Appointments.—Casualty surgical officer, casualty medical officer, six house surgeons, six house physicians, and two resident obstetric physicians. The above officers have residence and board in the college free of expense. Clinical clerks and dressers in all the departments are also appointed in addition to the foregoing.

Scholarships, &c.—Two entrance scholarships of the value of £100 and £75 in Arts and Science respectively. One entrance scholarship of the value of £50, open to Oxford and Cambridge students only. (Subjects—Anatomy and physiology, including histology.) "Emden" Cancer Research Scholarship, £100. "Richard Hollins," Research Scholarship, £105. Two Broderip scholarships of £60 and £40 respectively, for medicine and surgery; John Murray medal and scholarship, awarded every third year; the Governor's prize of £21 for students in their final year. Hetley clinical prize, value £25, awarded annually for proficiency in practical clinical medicine, surgery, and obstetrics; the Lyell Gold Medal and scholarship, value £55, in surgery and surgical anatomy; the Leopold Hudson prize, value 11 guineas, in surgical pathology, including bacteriology; Freeman scholarship, £30, in obstetrics and gynæcology; an exhibition of 10 guineas for anatomy and physiology to second years' students as well as class prizes in all subjects.

Fees.—General fee for the entire course of hospital practice and lectures, 135 guineas, if paid in one sum on entrance, or by instalments of 60, 50, and 35 guineas, payable at the commencement of the first, second, and third years respectively. For those who have completed their anatomical and physiological studies the fee is 70 guineas on entrance, or in two instalments of 40 and 35 guineas. The composition fee for London University students is 145 guineas. For those who have passed the preliminary science examination 120 guineas. The fee for the curriculum for dental students is 54 guineas on entrance, or two instalments of 40 guineas and 20 guineas.

ST. THOMAS'S HOSPITAL.—This hospital, with medical school attached, is situated on the southern Embankment of the Thames, facing the Houses of Parliament and contains 602 beds, in constant use. The school buildings, which are separated from the hospital by a quadrangle, comprise numerous theatres, laboratories, and class rooms, which are well adapted for the modern teaching of large bodies of students in all subjects of the medical curriculum. There is a large library and reading-room, and a very complete museum and gymnasium.

Appointments are open to all students. A resident assistant physician and a resident assistant surgeon are appointed annually at a salary of £100 with board and lodging. Four hospital registrars, two at an annual salary of £100 each, and two at £50 each, are appointed yearly. The tenure of these offices may be renewed for a term not exceeding two years. Four resident house physicians, two resident obstetric house physicians, and two ophthalmic house surgeons are appointed each six months, also out-patient officers, and clinical assistants in the special departments.

Scholarships, Prizes, &c.—Three entrance scholarships are offered for competition in September, *viz.*, one of £150 and one of £60 in chemistry, physics, and biology at the commencement of the second year; one of £50 open to University students who have passed in anatomy and physiology, for a medical degree in any of the Universities of the United Kingdom, and have not entered as students in any London Medical school. Numerous scholarships, prizes, and medals are open to competition throughout the whole career of a student, including a Fellowship of £100 given by the Salters' Company for research in pharmacology, and the Louis Jenner research scholarship, £60, for pathological research.

Special courses of instruction for the Preliminary Scientific and Intermed., M.B.Lond., for the Oxford and Cambridge examinations, and for the Primary and Final F.R.C.S. are held throughout the year.

A register of approved lodgings is kept by the medical secretary, who has a list of local medical practitioners and others who receive students into their houses. The prospectus of the school may be obtained on application to Mr. G. Q. Roberts, Secretary of the Medical School.

Fees.—A new system for payment of composition fees is in operation. Full details may be obtained of the Secretary.

UNIVERSITY COLLEGE HOSPITAL AND MEDICAL SCHOOL.—The hospital with college opposite are situated in Gower Street, not far from Euston railway terminus, and the Medical school in University Street, connected with the hospital by a subway. The number of beds available for teaching purposes is 277.

The new buildings for University College Hospital completed by the generosity of the late Sir Blundell Maple, Bart., were opened by H.R.H. the Duke of Connaught, on Tuesday, November 6th, 1906.

The new buildings for the Medical School, erected through the generosity of Sir Donald Currie, contain accommodation for undergraduate and post-graduate students in all departments of medical study subsequent to the intermediate course.

Appointments.—Eight house physicians, eight house surgeons, four senior and four junior obstetric assistants, and two ophthalmic assistants are selected annually by examination from among the senior students, without fee. The house physicians and house surgeons reside in the hospital for a period of six months, and the senior obstetric assistants for three months, and receive their board and lodging free.

The offices of out-patient physicians' and surgeons' assistants, clinical clerks, surgeons' dressers, and ophthalmic surgeons' assistants are filled by pupils who are also students of the college, without additional fee.

Scholarships, &c.—Entrance scholarship of the value of 135 guineas, and two exhibitions of 55 guineas each, and the Epsom free medical scholarship for proficiency in science, the subjects being those of the Preliminary Scientific Examination of the University of London, and two of 80 guineas each, the subjects being anatomy and physiology; the Atkinson-Morley surgical scholarship of £45 a year, tenable for three years; Atchison's scholarship, value £55, tenable for two years; Sharpey physiological scholarship, value about £105 a year; Filliter exhibition for proficiency in pathological anatomy, value £30; Erichsen prize, operating case, value £10 10s., awarded for practical surgery; Dr. Fellowes' clinical medals, the Liston gold medal, Alexander Bruce gold medal, Cluff memorial prize, Tuke medals for pathology, and other prizes, as well as certificates of honour, are awarded after competitive examinations in particular branches of study. The Tuffnell scholarship of £80 for chemistry two years; and the clothworkers' exhibition in chemistry and physics of £30 each, can also be held in the medical faculty.

Composition Fees.—The following have been grouped to meet the requirements of the various examining boards: A.—For the Courses required by the University of London. 1. For the Preliminary Scientific Course: 25 guineas, entitling to one attendance. 2. For the Intermediate Course: 55 guineas, if paid in one sum; 60 guineas if paid in two instalments. 3. For the Final M.B., B.S. Course: 80 guineas, if paid in one sum; 82 guineas, if paid in two instalments. This course of instruction is also suitable for the corresponding examinations at the Universities of Oxford, Cambridge, and Durham.

B.—For the Medical education required by the Examining Board in England and the Society of Apothecaries: 4. For the Course required for the First Examination: 20 guineas entitling to one attendance. 5. For the Second: 55 guineas, if paid in one sum; 60 guineas, if paid in two instalments. 6. For the Course required for the Third Examination: 80 guineas, if paid in one sum; 82 guineas, if paid in two instalments.

The composition fee in each case entitles to attendance on Lectures and Hospital Practice during three years.

C.—For Dental Students. Composition fee for the Courses required for the L.D.S., 65 guineas; or exclusive of chemistry, practical chemistry, physics, and materia medica, 50 guineas.

Students may repeat attendance at the Courses in chemistry and physics for £3 3s. (inclusive) and in elementary biology for £2 2s.

It should be noted that under the arrangement with the University of London, that body controls the medical science section of the medical school now, while the advanced medical subjects, that is the subjects after the intermediate course, are controlled by the University College Hospital Medical School.

Westminster Hospital.—This hospital is conveniently situated, facing the Abbey, and is readily accessible from all parts of the Metropolis. It contains 205 beds for general cases, and all the special departments. New school buildings have been erected close by which afford accommodation for 150 students. The class rooms, dissecting rooms, and lecture theatre are excellent samples of modern erections, affording ample scope for study.

Appointments.—Medical and surgical registrars, each £50 per annum; two house physicians, three house surgeons, one assistant house physician, one assistant house surgeon, and a resident obstetric assistant. These officers, except the two first named, are all boarded free of expense. Qualified students are appointed to be clinical assistants in the various departments.

Scholarships, &c.—(*a*) Winter Session—The Guthrie scholarship £60, entrance scholarship £40, entrance scholarship £30, dental scholarship £20; subjects, Latin, mathematics, English, and either Greek, French, or German. University scholarships, £60 and £40; subjects, anatomy and physiology. Natural science scholarship, £60, subjects, same as for Prel. Sci. of University of London. Natural science scholarship, £40, subjects, chemistry and physics. Free presentation, open to pupils of Epsom Medical College. (*b*) Summer Session.—Natural science scholarship, £60, same as winter. Natural science scholarship, £40, same as above. Arts scholarship, £60, arts scholarship, £40, University scholarships, £60, subjects same as in winter session. (*c*) Prizes, to be competed for by unqualified men. Chadwick, 20 guineas for students of any year not exceeding fifth. Bird medal and prize, £14 for students who have completed fourth winter session. Sturges prize in clinical medicine, £10, clinical surgery prize, £5. And class prizes in the various subjects.

Fees.—(*a*) For course required by Conjoint Board. In one payment of 120 guineas, or two payments of 65 guineas each, payable on entrance and at the commencement of second year respectively, or by six payments, distributed over six sessions, of 24 guineas each. (*b*) For the entire course of the University of London the composition fee is 130 guineas. Fees for shorter periods or for single courses may be learned on application to the Dean. Fees for dental students, payable in one sum on entrance, 50 guineas, or in two instalments, of £27 10s each.

London School of Medicine for Women (Royal Free Hospital).—The school is situated in Hunter Street, Brunswick Square, and the Royal Free Hospital is in Gray's Inn Road, close by. The school was re-built in 1898, and the laboratories are fully equipped for all the work required for the preliminary Scientific and Intermediate M.B. examinations of the University of London. A course of study is specially arranged for the work required by the Conjoint Colleges of Scotland and the Society of Apothecaries. Students are also prepared for the examinations of the various Universities. The Royal Free Hospital contains 165 beds available for clinical study; and there is a large out-patient and casualty department. In addition to the ordinary systematic lectures at the school, clinical lectures are given at the hospital in medicine, surgery, obstetrics, ophthalmology, and dermatology. Students hold clerkships and dresserships in each department.

Appointments.—A house physician, house surgeon, and a senior and junior resident obstetric assistant are appointed yearly. There are also non-resident appointments, including the anæsthetist and assistant anæsthetists, assistant and clinical pathologists, medical and surgical registrars, curator of museum and clinical assistants.

Fees.—The fee for the Intermediate and Final M.B. University of London course is £135 in one sum, or £145 in the following instalments:—first year, £45; second year, £40; third year, £40; fourth year, £20. The fee for the Preliminary Science classes is £25. The fee for the course for the Conjoint Colleges or Society of Apothecaries, including Elementary Science, is £140 in one sum, or in the following instalments:—first year, £50; second year, £40; third year, £40; fourth year, £20. Particulars as to Scholarships, &c., can be obtained from the Secretary, Miss Douie, M.B., 8 Hunter Street, W.C.

EXTRA-ACADEMICAL INSTITUTIONS IN LONDON.

Royal Institute of Public Health.—The Royal Institute of Public Health, was founded in the year 1886, with the object of obtaining the registration of public health diplomas and the further statutory requirement that all Medical Officers of Health should possess such a qualification, by which means it has succeeded in placing at the head of every public health administration in the Kingdom, a properly trained and specially qualified medical officer. The Council, with the object of providing a Central Institution in London, not only for instruction for the diploma and for scientific work in connection with public health, but also one to which those engaged or interested in preventive or tropical medicine may resort have acquired large and important premises in Russell Square, for the purposes of the Institute, providing a common room for the use of Fellows and Members, a lecture room, a reference library, laboratories for bacteriological and chemical and physical research, and laboratories in which the course of instruction for the diploma in public health can be taken, fitted up with all modern improvements.

The Institute is recognised as a public educational institution by the University of London, and its courses of instruction by the Universities and the Royal Colleges of Physicians and Surgeons. In pursuance of the above objects, the Institute publishes monthly *The Journal of the Royal Institute of Public Health.* Facilities are also afforded for municipal authorities, private medical practitioners, and others to obtain bacteriological and chemical reports.

The Institute is under the patronage of His Majesty the King, and the teaching staff consists of the Principal, Professor William R. Smith, M.D., D.Sc., F.R.S.E., Barrister-at-law; Demonstrator of Bacteriology, Carl Prausnitz, M.D., Breslau; Demonstrator of Chemistry, Mr. C. E. Harris, Ph.D.; Lecturer on Parisitology, Dr. Louis Sambon.

The next annual Congress (1908) will take place at Buxton.

THE ROYAL DENTAL HOSPITAL.—The teaching and hospital practice at this institution (situated in Leicester Square) are recognised by the various examining bodies. The new hospital and school which was opened six years ago, is complete in every detail with modern appliances. The clinic of the hospital is unrivalled, no less than 99,760 cases being treated in 1906. The following scholarships and prizes are open to all full term students:—Entrance scholarship, of the value ot £20, awarded in October. Subjects: Chemistry and dental mechanics. Saunder scholarship, of the value of £20, awarded to the student obtaining the highest aggregate number of marks in the various class examinations. Storer-Bennet research scholarship of the value of £50, awarded once in three years; the Alfred Woodhouse scholarship of £35, and the Robert Woodhouse prize of the value of £10, for practical dental surgery. Class prizes are awarded by the various lecturers. Provision is made for teaching mechanical dentistry, as required by the Royal College of Surgeons, the pupils being under the guidance of the staff of dental surgeons assisted by specially appointed demonstrators. The school contains an excellent library and a well-arranged museum.

Fees.—For the two years' hospital practice and lectures as required by the Royal College of Surgeons of England, the fee is £53 3s. in one instalment, or £55 13s. in two yearly instalments. The fee for the complete curriculum, namely, two years' instruction in mechanical dentistry and two years' hospital practice and lectures, is £150 if paid in one instalment, or 150 guineas if paid in three instalments of 50 guineas. For one year's instruction in mechanical dentistry the fee is 50 guineas. For one year's hospital practice, £21. The necessary course of two years at a general hospital can be taken simultaneously with that at the Royal Dental Hospital. Further particulars can be obtained on application to the Dean.

NATIONAL DENTAL HOSPITAL.—This institution is centrally situated (Great Portland Street, W.), and excellent teaching facilities and hospital practice are here obtainable, special demonstrations being given by members of the staff. There are also a mechanical laboratory, bacteriological laboratory, museum, students' common room, a metallurgical laboratory, extraction and stopping rooms, lecture hall, regulations room, &c., all lighted by electricity, and warmed and ventilated after the most approved requirements; in fact, this institution may be pronounced a model dental hospital and school. The winter session commences at the same time as at the medical schools, on October 1st. The medical tutors hold special classes before each college examination. The prizes include two entrance exhibitions, value £40 and £20, and the Rymer prize of £5 5s., the examinations for which are held in May and October. The fee for two years' hospital practice required by the curriculum, including lectures, is £40. (See advt.)

The two years' training in dental mechanics, required by the R.C.S. Curriculum, can be taken in the Mechanical Laboratory, and there is a "Composition Fee" including all the dental subjects of the curriculum of £120.

WOMEN AND CHILDREN.

THE HOSPITAL FOR WOMEN, Soho Square.—The hospital contains 61 beds. In connection with this institution there is now an organised school of gynæcology open to qualified medical men and to students after their third year. Clinical assistants to the physicians and surgeons in the in-patient and out-patient departments are appointed every three months. Fee for the three months' course, and certificate, £8 8s.

THE SAMARITAN FREE HOSPITAL FOR WOMEN, Marylebone Road, N.W., offers excellent opportunities to qualified medical men for clinical study and training in the details of operative gynæcology. Fee: three months, £3 3s. The success of the staff in this department has gained for them a European reputation. There are 51 beds.

Medical students are admitted to the practice of the following Metropolitan hospitals, to which no medical school is attached. Detailed particulars will be supplied on application to the various secretaries.

WEST LONDON HOSPITAL, Hammersmith.—This contains 175 beds, and has an extensive out-patient department. Dresserships and clinical clerkships may be obtained. Two house surgeons and two house physicians are selected every six months. There are special departments for diseases of the throat, nose and ear, skin, women and children, and deformities. Electrical and X-ray departments have also been added. The practice of this hospital is reserved exclusively for medical men, junior students not being admitted.

GREAT NORTHERN CENTRAL HOSPITAL, Holloway Road, N.—This institution has been greatly enlarged, contains 167 beds, cases in various special departments are treated, and the hospital is now recognised for study during the fifth year by the Conjoint Board. The practice of the hospital is open to practitioners and senior students, and clinical and pathological assistants are appointed in the wards and out-patient departments, as in the larger general hospitals.

BETHLEM ROYAL HOSPITAL.—In this Royal institution only cases of lunacy are received, and students intending to pursue this special branch have the best possible opportunities afforded here. The hospital contains 300 beds, and two resident house physicians who have recently obtained their diplomas to practise medicine and surgery are elected every six months, and are provided with apartments, complete board, attendance, washing, and an honorarium of 25 guineas per quarter. The students of certain specified London medical schools receive clinical instruction in the wards of the hospital, and qualified practitioners may attend for a period of three months on payment of a fee. Post-graduate lectures are also given.

NATIONAL HOSPITAL FOR EPILEPSY AND OTHER DISEASES OF THE NERVOUS SYSTEM, Queen Square, W.C.; contains 200 beds. This institution is recognised by the Conjoint Board where part of the fifth year of study may be devoted to clinical work. Clinical clerks are appointed to the physicians for out-patients, and courses of lectures and clinical demonstrations are given each year.

LONDON TEMPERANCE HOSPITAL.—The hospital contains 110 beds, and is conducted as its name implies on non-alcoholic principles by an excellent staff. The medical and surgical practice is open to students and practitioners. Appointments (vacancies for which are advertised in the medical journals): Surgical and medical registrars, resident medical officer, and one assistant resident medical officer.

METROPOLITAN HOSPITAL, Kingsland.—This was until recently known as the Metropolitan Free Hospital, is situated in the north-eastern district of the Metropolis, and contains 160 beds. It is a general hospital, with various special departments for the treatment of diseases of the eye, throat, ear, &c.

PRINCE OF WALES HOSPITAL TOTTENHAM.—This hospital contains medical and surgical wards and a ward for children, having in all 73 beds. There are special departments for gynæcological cases, diseases of the eye, ear, throat and nose, and skin diseases. It has now been authorised by the University of London to give certificates of post-graduate study for the M.D. and M.S. degrees.

HOSPITALS FOR CONSUMPTION.

HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST, Brompton.—The largest institution for the treatment of affections of the chest in the United Kingdom, there being 321 beds in the two buildings. There are four house physicians who reside in the hospital, each for a period of six months. Lectures and demonstrations are given by members of the medical staff on Wednesdays and Fridays at four o'clock, save during the vacations. Terms, £2 2s. for three months; £5 5s. perpetual. This hospital is recognised by the Conjoint Board, the University of London, and the Apothecaries' Society.

Mount Vernon Hospital, Hampstead and Northwood.—This institution, formerly called the North London Consumption Hospital, now carries on its work at Hampstead with 145 beds, and at Northwood with 100 additional beds, where treatment is carried out on the most modern lines, including the "open air" and other systems. Students are admitted to the practice of the hospital under certain conditions, and post-graduate courses are regularly delivered during the year.

City of London Hospital for Diseases of the Chest, Victoria Park.—This is a large and well-equipped hospital at the East End, containing 164 beds. Clinical lectures and demonstrations are given by the members of an exceptionally experienced staff. Fee for three months' attendance on hospital practice, 2 guineas; six months, 3 guineas.

Royal Hospital for Diseases of the Chest, City Road.—(80 beds.)—This hospital has been enlarged by the addition of a very complete out-patients' department, and also by the erection of a new wing, which provides accommodation for 80 in-patients.

Throat and Ear Hospitals.

Hospital for Diseases of the Throat, Golden Square, W.—This hospital has been recently rebuilt and contains 40 beds. Clinical instruction is given daily in the Out-patient Department on diseases of the nose, throat, and ear, and systematic courses of lectures are given during the winter session. There are nine clinics weekly, and an annual out-patient attendance of nearly 50,000. Major and minor operations daily (Mondays excepted) in different theatres. Four senior and thirty-six junior clinical assistants are appointed from among the students to assist the surgeons. Students are admitted to the practice of the hospital at the following fees:—Three months, £5 5s.; six months, £7 7s.; longer periods, £10 10s. Further details can be had by applying to the Dean.

Central London Throat and Ear Hospital.—This hospital contains accommodation for 22 in-patients, and new operating theatre. It has a very extensive out-patient department (over 50,000 attendances yearly), which is open daily to all medical practitioners and students, for the purpose of clinical demonstration and instruction. Courses of practical teaching are held twice weekly by members of the staff, which are open to qualified practitioners and advanced students. Each course is of about six weeks' duration, and includes hospital attendance for that period. The fee is 2 guineas.

Operations are performed daily (Saturday excepted) at 2 p.m.

Special attention is devoted to scientific work in the newly equipped laboratory. Full particulars will be supplied on application to the Dean.

Metropolitan Ear, Nose, and Throat Hospital.—The hospital was founded in 1838, and is situated in Grafton Street, Tottenham Court Road. The out-patient department is open daily at 2.30 p.m. to practitioners and students for acquiring clinical instruction and technical knowledge. Operations are performed on in-patients on Tuesdays, Wednesdays, and Thursdays at 9 a.m. Fee for one month's attendance at the hospital one guinea, and for three months two guineas. During the forthcoming session demonstrations will be given by members of the staff on the pathology and treatment of diseases of the ear and respiratory passages. Short practical classes will also be held in clinical pathology and surgical anatomy. Weekly clinical lectures are given by the staff on the special disease treated at the hospital.

Royal Waterloo Hospital for Children and Women.—This important institution, situated in South London has been in a transition state for some time past, having been partly rebuilt and appointed on ambitious lines, and when completed, as it is expected it will be soon, will contain 200 beds.

Hospital for Sick Children, in Great Ormond Street, Bloomsbury, and Cromwell House, Highgate.—Fee for three months' attendance, £3 3s.; perpetual, £5 5s. There are now 222 beds, besides 38 additional at the convalescent branch.

The practice of the Hospital is open to qualified medical men, and to students who have completed four years of medical study, the Hospital having been recognised by the Conjoint Board of England as a place where six months of the fifth year may be spent in clinical work. There are special ophthalmic, aural, dental, and electrical departments. There is also a Museum and Library in connection with the School. Lectures are given every Thursday afternoon during session by members of the staff, and certificates are granted.

For tickets and further information, apply to the Secretary, by letter, or by calling at the Hospital.

Eye Hospitals.

Royal London Ophthalmic Hospital, formerly in Moorfields, and recently rebuilt in the City Road, is the largest hospital devoted to this specialty in Great Britain, and contains 138 beds. Students and practitioners are admitted to the practice daily at 9 o'clock. Operations, 10 o'clock and after. Fee for six months, £3 3s.; perpetual, £5 5s. Further particulars of the Secretary.

Royal Westminster Ophthalmic Hospital, adjoins Charing Cross Hospital in King William Street. It has about 40 beds and a very large out-patient *clinique*. The lectures and demonstrations are arranged with special reference to the requirements of practitioners and senior students. Fee, six months, £3 3s.; perpetual, £5 5s.

Royal Eye Hospital, St. George's Circus, Southwark.—There are 40 beds and two cots. Fees, £2 2s. for three months, £3 3s. for six months, and £5 5s. perpetual. Courses are held on ophthalmoscopy, refraction, and diseases of the eye; fee, £1 1s. for each course, but perpetual students may attend each course once without extra fee. Pathology class, £1 1s. extra to cover cost of materials.

Central London Ophthalmic Hospital.—This hospital is situate in the Gray's Inn Road, has 26 beds and a large out-patient clinique. The post of clinical assistant is open to both men and women, who must be duly qualified and registered practitioners. During the winter session commencing in October lectures and demonstrations will be given in all the branches of ophthalmology. For syllabus and further particulars apply to the Dean.

Skin Hospitals.

St. John's Hospital for Diseases of the Skin.—Out-patient department, Leicester Square; In-patient department, Uxbridge Road, W. This hospital has a well-equipped in-patient department, with 50 beds. It has a School of Dermatology at 49 Leicester Square, which is conducted by the medical staff of the hospital. During the past year the free course of Chesterfield Lectures given by Dr. Morgan Dockrell has proved a great success, being well attended by the profession. The next course (free) will commence on Thursday, October 3rd, at 6 p.m., in the Lecture Room of the Hospital, Leicester Square. The subject of the opening lecture will be "The Present Position of Dermatology." The Out-patient Department has recently been rebuilt at a cost of £10,000, and contains a spacious laboratory and special electrical department which can be seen in operation every afternoon except Saturday. Clinical demonstrations are given every Monday (Dr. Morgan Dockrell) at 2 p.m.; Wednesday (Dr. Savill) at 3 p.m.; and Tuesday (Dr. Eddowes), at 2 p.m., on Selected Cases. (See Advt.)

One of the oldest institutions of the kind is the Western Skin Hospital (Great Portland Street), which was started as long ago as 1851. The practice of the hospital is open to students and practitioners. Students of this specialty have also the London Skin Hospital, in Fitzroy Square, with seven beds and an out-patient department of over 1,400. There is also the Stamford Street Skin Hospital, in the southern part of the Metropolis, with 10 beds and an out-patient department of 5,600, so that the students' needs in this direction are well catered for.

METROPOLITAN POST-GRADUATE INSTITUTIONS.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—This institution affords to medical men special facilities for acquiring technical skill, and advancing their medical and scientific knowledge. The building, which is large and commodious, is situated in Chenies Street, Gower Street, and contains lecture and consulting rooms, pathological and clinical laboratories, Röntgen ray room, an ophthalmoscope room, a library and museum, and reading and smoking rooms. *Cliniques*, at which patients are shown, are given every day of the week except Saturday, at 4 p.m. Lectures on Medicine, Surgery, and other allied subjects are delivered on Mondays, Tuesdays, Wednesdays, and Thursdays at 5.15 p.m. Four sessions of practical classes, each lasting six weeks, and a vacation session of three weeks' duration, are held during the year, the subjects taught comprising ophthalmology, otology, clinical microscopy, laryngology, urinary analysis, gynæcology, applied anatomy, nervous diseases, and practical X-ray work. There are, in addition, extra-mural classes in operative surgery and practical anatomy with dissecting. Special tutorial classes in medicine, surgery, midwifery, and pathology for gentlemen reading for the higher qualifications have recently been instituted, and are conducted regularly throughout the year.

A complimentary ticket for three days, admitting to *cliniques* and lectures, is issued to any medical practitioner on personal application at the college. The annual subscription for medical practitioners of either sex, holding qualifications granted in any of H.M.'s dominions—wherever resident—is One Guinea. Full information may be obtained from the medical superintendent, Mr. Hayward Pinch, F.R.C.S., 22, Chenies Street, Bedford Square.

WEST LONDON POST-GRADUATE COLLEGE.—The West London Hospital, Hammersmith Road, W., contains 160 beds; the post-graduate course was started in 1895, and this is the original post-graduate college in London attached to a general hospital. Instruction is given in the out-patient department daily at 2.15 p.m. by the assistant physicians and assistant surgeons. The physicians and surgeons attend daily at 2.30 p.m., when post-graduates can accompany them in their visits to the wards. Operations are performed daily at 2.30 p.m. There are lectures every evening at 5 p.m. (Saturdays excepted). Special classes are held in bacteriology, diseases of the eye, throat, X rays, anæsthetics, intestinal surgery, tropical medicine, cystoscopy, operative surgery, &c.

Fees.—The fee for the hospital practice including all the ordinary lectures and demonstrations, is £1 1s. for one week; £2 2s. for one month; £5 5s. for three months; £8 8s. for six months; £12 12s. for one year, and £25 for a life ticket. A course of attendance on either the medical or surgical practice alone may be taken out for the fee of £3 3s. for three months. The fee for three months' attendance in any one special department, other than medicine or surgery is £2 2s. A prospectus containing full particulars will be forwarded on application to Mr. L. A. Bidwell, Dean.

NORTH-EAST LONDON POST-GRADUATE COLLEGE.—This post-graduate school is established in connection Prince of Wales's General Hospital, Tottenham, N., which is recognised by the University of London as a place of post-graduate study for the M.D. and M.S. degrees, and by the India Office for purposes of study leave. Facilities are here afforded to qualified medical practitioners for taking part in the work of an active general hospital, and for attending demonstrations of various branches of medicine surgery, and gynæcology, with opportunities for clinical instruction in diseases of the eye, ear, throat, nose, skin, in fevers, psychological medicine, the administration of anæsthetics, radiography and dentistry. Cliniques, lectures and demonstrations are given by members of the teaching staff in the lecture room, in the wards, in the various out-patient departments, and in certain affiliated institutions. Operations are performed every afternoon of the week, except Saturday. Special classes, the attendance at which will be limited, are arranged in gynæcology, the surgical diseases of children, including orthopædic surgery, diseases of the throat, nose and ear, diagnosis of diseases of the nervous system, ophthalmoscopy and refraction, analysis of gastric contents, clinical examination of the blood, diseases of the skin, abdominal surgery, radiography, bacteriology, and medical electricity. The fee for a three months' course of study, which may be begun at any time, in any single department, is one guinea. A fee of three guineas admits to the whole practice of the hospital for a similar term (one month, 2 guineas), and a perpetual ticket for the practice of the hospital may, for the present, be obtained on payment of a fee of 5 guineas. The opening lecture of the Winter Session will be given by Dr. W. Hale White, at 4 p.m., on Thursday, October, 3rd. Additional information with a syllabus of lectures, demonstrations, and special classes, may be obtained from the Dean of the Post-Graduate College, Dr. A. J. Whiting, 142 Harley Street, W.

LONDON POST-GRADUATE ASSOCIATION.—This Association offers facilities for Clinical Study to qualified medical men. Joint cards of admission are issued to the Clinical Instruction of the following General Hospitals and Schools of Medicine:—Charing Cross, Guy's, Westminster, St. Thomas's, University College, St. Mary's, King's College, besides several special hospitals. *Fee.*—For three months, 10 guineas; for six months, 15 guineas; and for any longer period at the further rate of 9 guineas for each additional six months. Further particulars may be obtained of the Secretary, London Post-Graduate Association, Examination Hall, London, W.C.

The following are the principal provincial hospitals having the greatest number of beds, to which students are admitted where clinical instruction can be obtained, but to which there is no medical school attached :—

BRADFORD INFIRMARY.—The hospital contains 220 beds. Non-resident pupils are received and abundance of clinical material is obtainable. One year's attendance is recognised by the Examining Boards. Fee, perpetual, £10 10s.

LIVERPOOL NORTHERN HOSPITAL, which has recently been rebuilt, now contains 246 beds, and is completely equipped with the most modern appliances. Clinical instruction is given by the staff during the summer and winter sessions. Clinical clerkships and dresserships are open to all students without additional fees. Fees for hospital attendance: Perpetual, £26 5s.; one year, £10 10s.; six months, £6 6s.; three months, £4 4s.; practical pharmacy, £2 2s.

NORFOLK AND NORWICH HOSPITAL.—This hospital is recognised by the Colleges, and contains 220 beds. Fees, £10 10s. for six months, £15 15s. for twelve months' medical and surgical practice. Pupils, resident and non-resident, are admitted.

NORTHAMPTON GENERAL HOSPITAL.—This hospital contains 174 beds; it has been recently enlarged and re-arranged. Non-resident pupils are received and have every opportunity of acquiring a practical knowledge of their profession. The fee is £10 10s.

ROYAL BERKSHIRE HOSPITAL.—The town of Reading, in which this hospital is situated, has a very large working-class population, and excellent opportunities for clinical instruction in the wards and extensive out-patient department are afforded here. It contains 160 beds, a splendid library, in which the Reading Pathological Society holds its mettings.

WOLVERHAMPTON GENERAL HOSPITAL.—The hospital contains 230 beds, attendance at this hospital being recognised by all the Examining Boards. Pupils are trained in clinical work by the medical and surgical staff. *Fees;* Six months, £6 6s.; twelve months, £12 12s.; perpetual, £21.

Ireland.

THE IRISH MEDICAL SYSTEM.

The system of medical teaching in Ireland differs from that in England in important particulars. In London each clinical hospital has its attached medical school, which is fully equipped, and which educates the students of that hospital and very seldom those of any other. In Dublin, on the contrary, the hospitals and schools are entirely separate (except that Sir Patrick Dun's Hospital is officially connected with Trinity College), and a student of any hospital is free to enter for the whole or any part of his course at any school or hospital he pleases.

COST OF MEDICAL EDUCATION IN IRELAND.

The cost of obtaining a medical qualification depends to some extent on the qualification sought. In this connection the following tables may be of use to the prospective student :—

COST OF MEDICAL EDUCATION.

School of Physic, Dub. Univ. ..	£122 6s. 6d.
Royal College of Surgeons School	£124 19s.
Catholic University School ..	£124 19s.
Queen's College	About £110

COST OF DIPLOMAS OR DEGREES.

Dublin University	£27 (to this must be added £83 4s., the cost of obtaining an Arts degree).
Royal University	£15.
Conjoint Royal Colleges ..	£42.
Apothecaries' Hall	£22 1s.

Thus, the absolute payment will amount to somewhere between £125 and £232 10s. 6d. according as the teaching of the Queen's Colleges and the degrees of the Royal University, or the teaching and degrees of Dublin University, are taken. For the Conjoint Colleges the entire cost is £166 19s., taking the minimum mode of payment. So that, assuming that extras or voluntary costs are incurred the total will vary, say, from £170 to £200. "Grinding," although not officially recognised, occupies a position almost identical with that of the extra-mural instruction in other schools. Its cost must be reckoned among the expenses of the course, for, while not essential, it has become customary for almost all students to obtain aid in their studies in this way. As a rule, this private instruction costs about £5 5s. for each of the four examinations.

The above sum, or something like it, may be expended by the student or his parent in paying for lectures, &c., and examination fees as they fall due, and there is no difficulty in obtaining the needful information for his guidance if he likes to pay for his course in this fashion.

All the Dublin schools require fees to be paid in advance.

DATE OF ENTRY.

The entry of names and commencement of study in Ireland is *supposed* to date from the 1st of October in each year, but the session really dates from the 1st of November, and the entry of names may be delayed by the dilatory to the 25th of the same month. It should, however, be remembered that no credit is given for studies or attendance until the entry is regularly made. The student must attend three-fourths of the lectures delivered, and if he loses a fortnight at the beginning he must make up for it afterwards by constant attendance.

The student begins work by attending a recognised medical school each morning at ten o'clock, and occupying his day, to five p.m., between lectures and dissections. His vacations are a fortnight at Christmas and a week at Easter, and he finally returns home at the end of June.

PRELIMINARY EXAMINATIONS.

The first act of the student is to pass a preliminary examination, without which he cannot get credit for any medical studies pursued. The next is to commence medical study. This he does by entering for lectures at a medical school. From the school registrar he gets a form of certificate, and his third act is to take it or send it to the Branch Medical Council, 35 Dawson Street, Dublin, unless, as is usually the case, this duty is undertaken for him by the school registrar. He is thereupon placed upon the Register of Medical Students (without fee), and his period of study counts from that date. He must register at the earliest possible moment, or he may lose credit for his work.

The only preliminary examination held specially for medical students is that held conjointly by the Royal Colleges of Physicians and Surgeons, but other examinations, *e.g.*, the public entrance at Trinity College, the matriculation of the Royal University, the Intermediate Examination passes in the required subjects, and all other examinations recognised by the General Medical Council are accepted as equivalent.

The subjects of examination as prescribed by the General Medical Council are as follows :—1. English language, including a specified author, dictation, grammar, and composition ; also parsing and analysis from a book specified. 2. Latin, including grammar, translation from specified authors, and translation of easy passages not taken from such authors. 3. Elements of mathematics, comprising (*a*) arithmetic, including vulgar and decimal fractions ; (*b*) algebra, including simple equations ; (*c*) geometry, Euclid, Books I., II., and III., with easy deductions. 4. One of the following optional subjects :—(*a*) Greek, (*b*) French, (*c*) German.

THE IRISH LICENSING BODIES.

The Medical Licensing Bodies of Ireland are four in number, and, as a rule, students gravitate into one or other of five classes :—*a.* Those who enter Trinity College, and take a full graduation in Arts in addition to their professional degrees. *b.* Those who take the licence of the conjoint Royal Colleges of Physicians and Surgeons. *c.* Those who take their qualifications at the Royal University of Ireland, where graduation in Arts is not necessary. *d.* Those who take the licence of the Apothecaries' Hall. *e.* Those who pursue their studies in Ireland, but who migrate to London, Edinburgh, or Glasgow for their licences. Almost all these last-named emigrants come from the Queen's Colleges, and the greater number of them from Belfast, while the Dublin students qualify, as a rule, in Dublin.

We do not attempt to give details as to the requisite courses of instruction for degrees or diplomata, as our epitome must necessarily be insufficient for the information of the student, and we can occupy our available space with information more useful to him. The official information upon which students may depend can be obtained by sending a note to the Registrars of the Licensing Bodies or Schools.

THE UNIVERSITY OF DUBLIN.

The University of Dublin grants the degrees of M.B., B.Ch., and B.A.O. to students who have obtained their Arts degree, and who have been for at least five academic years on the books of the Medical School, and the higher degrees of M.D., M.Ch., and M.A.O. to those who have held, or have been qualified to hold, for at least three years, the degree of M.B. and B.Ch. It does not grant degrees to any but full graduates in Arts, consequently its degrees hold the highest rank of social and educational qualifications, and are sought for by those who look forward to occupying the best positions in the profession.

The expense of obtaining the degrees of M.B., B.Ch., and B.A.O. is approximately as follows :—Lectures, £67 4s. 0d. ; Hospitals, £55 13s. ; Degree Fees, £27.—Total, £149 17s. 0d.

The expense of the B.A. degree, amounting altogether to £83 4s., should be added, making the total cost £233 1s. 0d.

In addition to its ordinary qualifications the University grants the following higher degrees :—

Doctor of Medicine.—To obtain this the candidate must have obtained the degree of M.B., or have been qualified to have obtained it for three years. He must then read a thesis before the Regius Professor of Medicine. Fee for this degree, £13.

Master of Surgery.—The candidate must be a Bachelor in Surgery of three years' standing, and must then pass an examination in clinical surgery, operative surgery, surgical pathology, surgery, and surgical anatomy (on the dead subject). Fee for this degree, £11.

Master in Obstetric Science.—The candidate must have passed the M.B. and B.Ch. examinations, and have completed, in addition to the courses for M.B., B.Ch., a course of obstetric medicine and surgery. He is then required to pass an examination in the following subjects:—Practice of midwifery, gynæcology, anatomy of female pelvis and elementary embryology, and clinical gynæcology. Fee for this degree, £5.

Diplomate in Medicine, Surgery, and Midwifery — Candidates for the diplomas in Medicine, Surgery, or Obstetric Science must be matriculated in Medicine, and must have completed two years in Arts and five years in medical studies. The medical course and examinations are the same as for the degrees, Fees for the diplomas in medicine, surgery, and midwifery, £21. A diplomate, on completing his course in Arts and proceeding to the degree of B.A., may become a Bachelor by paying the degree fees.

Diploma in Public Health.—The candidate must be an M.D. or a Graduate in Medicine and Surgery of Dublin, Oxford, or Cambridge, must have completed, subsequent to registration, six months' practical instruction in a laboratory, and also have studied practically outdoor sanitary work for six months under an approved Officer of Health.

Degree and Licence in Dental Science.—Candidates for the degree in dental science must have taken a degree in Arts, and must have had their names in the books of the Medical School for five years. Two examinations must be passed—namely, the Previous Dental at the end of the second year, and the Final Dental at the end of the fifth year. Candidates for the Licence are required to matriculate in Arts, and pass one Term Examination. The course of study is the same as for the degree with the exception that no lectures in pathology or bacteriology are required. The total fees for the licence, including the premium for Dental Mechanics (£100), are £200 17s., while those for the degree are about £210, to which must be added the cost of the B.A. degree.

Post-Graduate Classes.—A short post-graduate course is now given annually in July in connection with Trinity College Medical School. It includes special work on Diseases of the Eye, Nose, and Throat, Gynæcology, Diseases of the Skin, X-ray work, Medicine, Surgery (clinical and operative), and Clinical Pathology.

Royal Services School.—The object of this school is to prepare candidates for the Indian Medical Service, and Royal Army Medical Service. It is conducted on a comprehensive scale, and affords special opportunities for operating on the cadaver, and for the study of commentaries. Two sessions are held yearly, each lasting for about ten weeks.

THE ROYAL UNIVERSITY OF IRELAND.

THE Royal University of Ireland is purely an examining body. Its degrees are granted on one year's acts, *i.e.*, the matriculation examination of this University and a "first University examination" at the termination of the first year. The cost of the M.B. and M.Ch. of the University, with all the necessary curriculum, is about £125. Some of the Arts examinations are conducted, not only in Dublin, but at certain local centres.

The University confers the following medical degrees:—

M.B., B.Ch., B.A.O., and the higher degrees of M.D., M.Ch., and M.A.O. It also confers a Diploma in Public Health and a Diploma in Mental Diseases.

All degrees are open to persons of either sex who shall have passed the Senior Grade Examination of the Intermediate Education Board for Ireland in the subjects prescribed for the Matriculation Examination of the University, and who shall apply for exemption from the Matriculation Examination in the year in which he shall have passed such examination.

The University examinations are held in the spring, beginning about the middle of April, and in the autumn, beginning towards the close of September.

All candidates for any degree must pass the matriculation examination, or the Senior Grade Examination or the Intermediate Education Board (as above mentioned) and the first University examination.

The course for the degree of M.B., B.Ch., B.A.O., extends over five years.

Students will be admitted to the first University examination after one year from matriculation. Fee, £1.

The medical course consists of three previous examinations, one at the end of each year, and one degree examination at the end of the fifth year. Fee for each previous examination, £1; for the degree examination, £2; for the diploma, £10.

In addition, the following degrees are granted:—

Diploma in Public Health.—Conferred only on graduates in medicine of the University of at least twelve months' standing. Fee, £2. Subjects.—Meteorology, bacteriology, chemistry, physics, vital statistics, hygiene, sanitary engineering, architecture and law.

The M.D. Degree.—Conferred only on graduates in medicine of the University of three years' standing. They must at the same time produce a certificate of having been, for at least two academical years, engaged in hospital or private, medical, surgical, or obstetrical practice, or in the military or naval medical service. The examination comprises medical diseases and the theory and practice of medicine, including pathology. Every candidate will be examined at the bedside, and be required to diagnose at least three medical cases, and prescribe treatment, and to write detailed reports on at least two cases to be selected by the examiners and to discuss the questions arising therefrom. Fee, £5.

The M.Ch. Degree.—Conferred only on graduates in medicine of the University of three years' standing, and who can produce a similar certificate of practice to that required for the M.D. degree. The examination comprises surgery, both theoretical and operative; surgical anatomy; ophthalmology and otology. Fee, £5.

The M. A. O. Degree. — Conferred only on graduates in medicine of the University of three years' standing, and who can produce a similar certificate of practice to that required for the M.D. and M.Ch. degrees. The examination comprises midwifery and diseases of women and children. Fee, £5.

Prizes, &c.—First Examination in Medicine. Two first-class exhibitions of £20 each, and two second of £10 each.

Second Examination in Medicine.—Two first-class exhibitions of £25, and two second-class of £15, and the Dr. Henry Hutchinson Stewart Medical Scholarships, value £10 a year for three years.

Third Examination in Medicine.—Two first-class exhibitions of £30 each, and two second of £20 each.

Medical Degrees Examination. At each of the two Examinations in the year three Exhibitions of £21 each in the groups of medicine, surgery and midwifery. One travelling medical scholarship of £100. One medical studentship of £200 per annum, tenable for two years.

The Dr. Henry Hutchinson Stewart Scholarship for proficiency in the Knowledge of Mental Diseases for competitions among medical graduates if not more than three years' standing. This Scholarship is of the annual value of £50, tenable for three years.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

These examinations are held conjointly by the two Colleges. The course, as in other bodies, extends over five years, with examinations at the end of the first, second, third, and final years. These examinations are conducted by examiners chosen by each of the Colleges for the subjects appropriate to them. The curriculum has recently been revised, and made of a more practical nature. In common with the English Colleges, the subjects of the

First Professional examination may be studied either at a medical school or at an institution other than a medical school recognised by the Colleges, after due inspection, for instruction in these subjects. We recommend students to apply for the official programme to the Secretary of the Committee of Management, Royal College of Physicians, or to the Registrar of either College. In the case of the Preliminary Examination seven clear days' notice must be given to the Secretary; fourteen days' notice is required from candidates for the Professional examination.

The total of the examination fees, spread over the four examinations, is £42, while the school and hospital fees, if taken in Dublin, amount to £124 19s., making altogether £166 19s., exclusive of re-examination fees, which have to be paid in case the candidate fails to pass his examination.

The Conjoint Colleges also confer a diploma in Public Health, of which information will be found on page 280.

ROYAL COLLEGE OF PHYSICIANS.

This College issues a Licence in Medicine and a Licence in Midwifery to Registered Medical Practitioners.

Licence in Medicine.—The subjects of examination are:—Practice of Medicine, Clinical Medicine, Pathology, Medical Jurisprudence, Midwifery, Hygiene and Therapeutics.

Licence in Midwifery.—The subjects of examination are:—Gynæcology and Midwifery. A Registered Medical Practitioner of five years' standing is exempted from the examination by printed questions.

Fees.—Fee for the Licence to Practise Medicine £15 15s. Fee for the Licence to Practise Midwifery £5 5s.

Membership.—The Membership is open to University Graduates in Medicine and to Licentiates of the Royal Colleges of Physicians of the United Kingdom. The Examinations for Membership are held in January April, July, and October, and such other times as the President may appoint.

ROYAL COLLEGE OF SURGEONS IN IRELAND.

This College grants a licence in Surgery to registered medical practitioners. Candidates who hold registrable surgical diplomas, including the licence of the Apothecaries' Society of London, and the Apothecaries' Hall, Dublin, granted since October, 1886, are admitted to examination without further evidence of study, but candidates who hold medical qualifications only, including the L.S.A. and L.A.H., granted before October, 1886, will be required to produce certificates of two courses of lectures in anatomy and dissections, one course of practical histology, one course of lectures in surgery, and one course of operative surgery.

Candidates are examined in surgery, clinical and operative; surgical appliances; and ophthalmic surgery. The fee is £26 5s. The fee for a special examination is £31 10s.

A diploma in Midwifery is also granted after examination to registered medical practitioners. Candidates must produce evidence of (*a*) attendance on a course of lectures on midwifery and diseases of women and children in a recognised school; (*b*) attendance or six months' practice at a recognised lying-in hospital or recognised dispensary for lying-in women and children; and (*c*) of having conducted at least thirty labour cases. The fee for the examination is £15 15s.

Fellowship.—Candidates for the Fellowship of the College must enter their names with the Registrar at least a month before the date of examination, in order that the Council may decide whether to approve of the application. Examinations are held the third Mondays in February, May, and November. If the application is approved, the candidate will be admitted to the next sessional examination or to a special examination (except during the months of August and September) if granted by the Council. Candidates are divided into two grades:—

Grade 1.—Licentiates or graduates in surgery of less than ten years' standing.

Grade 2.—Licentiates or graduates in surgery of more than ten years' standing.

Students, not either Licentiates or Graduates in Surgery, are permitted to present themselves for the *Primary* Examination under Grade I.

Candidates in Grade 1 must pass two examinations—Primary (in anatomy and physiology) and Final (in surgery). Candidates in Grade 2 need pass but one examination in surgery, surgical anatomy, and surgical pathology.

Fees.—Grade 1.—For Licentiates of College; Primary examination, £15 15s.; Final examination, £10 10s. Licentiates in Surgery of other licensing bodies: Primary examination, £26 5s.; Final examination, £15 15s. Students of the College: Primary examination, £5 5s.; Final examination, £21. Students of other licensing bodies: Primary examination, £10 10s.; Final examination, £31 10s.

Grade 2.—Licentiates of the College, £26 5s.; Licentiates in Surgery of other licensing bodies, £42.

LICENCE IN DENTAL SURGERY.

There is probably no specialty in surgery which gives as great a number of its practitioners a living and the prospect of an income as dentistry. A young man who has got his diploma and knows something of his business, and is willing to attend to it, seldom fails to get a substantial foothold in Ireland in a few years. The University of Dublin grants both a Degree and a Licence in dental surgery. To obtain the former, candidates must have taken a degree in arts; the licence is obtainable by all duly qualified persons who have passed the Public Entrance Examination of Trinity College, Dublin. The Royal College of Surgeons in Ireland grants a Licence in Dentistry.

Course of Study for the Licence in Dentistry.—Candidates are required to pass three examinations, *viz.*:—Preliminary (in General Education), Primary Dental, and Final Dental.

All information concerning this licence may be obtained from the Registrar of the College. The Primary Dental Examinations commence on the second Monday in the months of February, May, and November. The subjects of examinations include physics, chemistry (including metallurgy), anatomy, physiology and histology, and surgery. The fees for the primary Dental Examination amount to £10 10s; and for re-examination, if rejected, £5 5s. The Final Dental Examinations commence on the Thursdays immediately following the Primary Dental Examinations. Candidates are examined in dental surgery, theoretical (including dental pathology), clinical, and operative; and in dental mechanics, theoretical, clinical, and practical (including the metallurgy of the workshop). Candidates must pass in all the subjects at the same time.

The fees for the Final Dental Examination in the case of candidates holding the L.R.C.S.I., or students who have passed the Primary Dental or Third Professional Examination of the College, £10 10s.; re-examination, £5 5s. The fees for Final Examination of all other candidates, £26 5s., and for re-examination, £10 10s. The extra fee for Special Examination, £5 5s. A rejected candidate will not be again admitted to examination until after a period of three months.

APOTHECARIES' HALL OF IRELAND.

The Licence of this Hall is granted to students who present certificates of having fully completed the course of study as laid down in the curriculum, and who pass the necessary examinations. The diploma of the Apothecaries' Hall of Ireland entitles the holder to be registered as a practitioner in medicine, surgery, and midwifery, and he also possesses the privileges of an apothecary.

There are four professional examinations, the total fees for which amount to 21 guineas. Women are eligible for the diploma.

Registered Medical Practitioners will receive the diploma of the Hall upon passing an examination in the subject or subjects not covered by their previous qualification, and on paying a fee of ten guineas; if medicine or surgery is required, five guineas extra will be charged.

The fees payable for each examination are as follows: First Professional, £5 5s.; Second, £5 5s.; Third, £5 5s.; Final Examination, £6 6s.

A candidate is allowed for each professional examination which he has completed at any other licensing body, except the Final. If he has passed only in some of the subjects in a given examination, he has to pay the whole of the fee for that examination.

The fees for re-examination are: For each subject, £1 1s., excepting in the subjects of chemistry, pharmacy, surgery, medicine, second anatomy, physiology, pathology, and ophthalmology, the fees for which are £2 2s. each.

The fee for the Third and Final, or Final alone, is £15 15s., when the other examinations have been taken elsewhere.

All examination fees are to be lodged in the Sackville Street Branch of the Royal Bank of Ireland to the credit of the Examination Committee.

Applications and schedules, together with bank receipt for the fee, must be lodged with the Registrar, Apothecaries' Hall, 40 Mary Street, Dublin, at least fourteen clear days before the day of examination.

Candidates who desire to obtain the Letters Testimonial of the Apothecaries' Hall of Ireland, must, before proceeding to the Final Examination, produce evidence of having been registered as medical students for fifty-seven months; also of having attended courses of instruction as follows:

One course each (winter course of six months) of the following: Anatomy (lectures), chemistry (theoretical), midwifery, practice of medicine, physiology and surgery. Dissections, two courses of six months each. Courses of three months.—Materia medica, medical jurisprudence, chemistry (practical), practical physiology and histology, operative surgery, physics, clinical ophthalmology, biology, clinical instruction in mental disease, pathology, and a course in vaccination.

Medico-Chirurgical Hospital, twenty-seven months to be distributed over the last four years of study. The candidate may substitute for nine months in this, hospital attendance six months as a resident pupil.

Three months' study of fever.

Six months' practical midwifery and diseases of women.

Three months' practical pharmacy in a recognised clinical hospital or a recognized school of pharmacy, or a year in the compounding department of a licentiate apothecary or a pharmaceutical chemist.

Each candidate before receiving his diploma must produce evidence that he has attained the age of 21.

Each candidate must produce evidence of having before entering on medical studies passed a preliminary examination in general education recognised by the General Medical Council, and of having been registered by that Council as a student in medicine. Certificates of medical study will not be recognised if the commencement of the course to which the certificate refers dates more than fifteen days prior to such registration, except in the subjects of physics and biology. This registration is not undertaken by the Hall.

The details of the course of education required and syllabus of the examinations will be supplied on application to the Registrar, at 40 Mary Street, Dublin.

THE DIPLOMA IN PUBLIC HEALTH.

This diploma is granted by Dublin University, the Royal University, and the Conjoint Royal Colleges. Every candidate must be a registered medical practitioner. The examination is in:—(1) Chemistry (including chemical physics). (2) Engineering and architecture. (3) Sanitary law and vital statistics. (4) Hygiene. (5) Bacteriology. (6) Meteorology. The General Medical Council recommend that all candidates shall have studied in a special bacteriological laboratory, also for six months as pupil of a working medical officer of health, described, for Ireland, as "the medical officer of health of a county or of one or more sanitary districts having a population of not less than 30,000; or a medical officer of health who is a teacher in Public Health of a recognised medical school."

In addition to taking the prescribed course a candidate for the D.P.H. of the University of Dublin must be a Doctor in Medicine or a graduate in Medicine, Surgery, and Midwifery of Dublin, Oxford, or Cambridge, and his name must have been on the "Medical Register" for at least twelve months before the examination. The Royal University only confers its diploma on its own graduates.

THE DIPLOMA IN PSYCHOLOGICAL MEDICINE.

The Royal University of Ireland grants a diploma for proficiency in the treatment of mental diseases under the following conditions:—

The diploma is conferred only on graduates in medicine of the University. Candidates must give notice, in writing, to the secretaries of their intention to present themselves, and must pay the prescribed fee of £2 at least one month previous to the examination. Candidates who satisfy the examiners will be required to pay a further fee of £3 before the diploma is conferred The subjects for this examination are those required by the Hutchinson Stewart Scholarship for proficiency in the treatment of mental diseases.

THE IRISH MEDICAL SCHOOLS.

The Irish Medical Schools are as follows:—

The School of Physic of Dublin University.—This school is formed by an amalgamation of the School of Trinity College and of the College of Physicians.

Every student of the school must be matriculated by the Senior Lecturer, for which a fee of 5s. is payable, but he need not attend any of the Arts course unless he desires to obtain a University licence or degree in medicine, surgery, and midwifery. No student is permitted to matriculate unless he has passed the Entrance and a Term examinations of the University, of the Royal University, of the College of Surgeons, or some other examination recognised by the General Medical Council.

Two medical scholarships are given annually at the School of Physic, value £20 per annum, tenable for two years, the examinations for which are held each year in June; one scholarship is given in anatomy and institutes of medicine; the other in zoology, chemistry, botany, and experimental physics.

A prize of £100 is awarded by the Board to the successful candidate at a special examination in alternate years in medicine or in surgery, provided that the merit be deemed sufficient. The successful candidate is required to spend three months in the study of medicine or surgery, as the case may be, in Berlin, Paris, or Vienna. Before he can obtain the first instalment of £50 he must satisfy the Senior Lecturer that he possesses sufficient knowledge of a Continental language to derive full benefit from the prize. The examination is held in June, and is open to students who have passed the Final Examination in Medicine or in Surgery, as the case may be, within two years of the examination.

In order to obtain the second sum of £50 the prizeman must have furnished to the Regius Professor his formal report on the hospitals attended by him within two years from the time of obtaining the prize.

The Sir John Banks Medal and Prize, founded by Sir J. Banks, M.D., formerly Regius Professor of Physics, are awarded both for best and second best answers at the Medical Travelling Prize Examination.

The Edward Hallaran Bennett Medal, founded by pupils of the late Dr. E. H. Bennett, formerly Professor of Surgery, is awarded to the Surgical Travelling Prizeman.

Class prizes are given at the end of the session of between £5 and £10 in value.

The John Mallet Purser Medal, founded by Prof. Purser's past pupils, is awarded annually to the student who, at the ordinary June Intermediate Medical Examination, Part I., in Anatomy and Institutes of Medicine, shall obtain highest marks in Physiology and Histology, provided that he passes the examination in full.

Fitz-Patrick Scholarship.—This scholarship consists of the interest on £1,000. It will be awarded annually to the student who obtains the highest aggregate marks at the five sections of the Final Examinations, provided that he has completed his medical course in the prescribed period of five years.

THE ROYAL COLLEGE OF SURGEONS IN IRELAND. SCHOOLS OF SURGERY.—These schools are attached by Charter to the Royal College of Surgeons, and have existed as a department of the College for over a century. They are carried on within the College buildings, and are specially subject to the supervision and control of the Council, who are empowered to appoint and remove the professors, and to regulate the methods of teaching pursued. The buildings have been reconstructed, the capacity of the dissecting room nearly trebled, and special pathological, bacteriological, public health, chemical, and pharmaceutical laboratories fitted with the most approved appliances, in order that students may have the advantage of the most modern methods of instruction. A refreshment room is now open, where students can have luncheon. There are special rooms set apart for lady students. The entire building is heated by hot-water pipes, and lighted throughout by the electric light.

All the lectures and courses of practical instruction may be attended by medical students who are otherwise unconnected with the College.

All the diplomas of the College are open to students of either sex. Separate rooms have been provided, and careful provision made for the instruction and comfort of women students.

Prizes.—The Barker Prize, £31 10s.; the Carmichael Scholarship, £15; the Mayne Scholarship, £8. The Gold and Silver Medals in Surgery and the Stoney Memorial Gold Medal in Anatomy.

Class Prizes of £2 and £1, accompanied by medals if sufficient merit is shown, will also be given in each subject. Prospectus and Student's Guide can be obtained on written application to the Registrar, Royal College of Surgeons, Dublin.

Two short post graduate courses are held in the year. Full particulars can be obtained from the Registrar.

THE CATHOLIC UNIVERSITY SCHOOL is situated in Cecilia Street, Dame Street. It prepares students for all medical examinations, particularly those of the Irish Colleges of Physicians and Surgeons, and the Royal University of Ireland. The school has recently been rebuilt and refitted, its working space having thereby been nearly doubled, and several new laboratories, including those for the study of bacteriology and public health, have been added. The institution has also been recently chartered, under the Educational Endowment (Ireland) Act, and it is now controlled by a Board of Governors. The total fees for school and hospital courses is £160, payable as the courses are taken out.

The following Exhibitions are awarded annually:—Two first year's, value £12 10s. each; two second year's, value £10 each; one third year's Royal Exhibition of £12 10s.; one final Conjoint Colleges Exhibition of £12 10s.; two large gold medals, besides several other class medals.

A Guide for Medical Students, which gives all the information required by parents, and by students who desire to join the medical profession, may be obtained free on application to the Registrar.

THE QUEEN'S COLLEGES—BELFAST, CORK, AND GALWAY.

These three important academic institutions educate students for all colleges and degrees, and are maintained, as hitherto, by a Government grant. The same curriculum as that formerly adopted is continued, and the various exhibitions and scholarships are still available. Each college has the disposal of about £1,500 per annum in scholarships and prizes. The colleges are well adapted for high-class technical education, having lecture rooms provided with every appliance necessary in the modern training of a medical student. The colleges are completely equipped with students' reading rooms and lending libraries and refreshment rooms, and with all adjuncts to collegiate life, such as literary societies and athletic organisations. The expense of living in the collegiate towns is quite moderate. The course of lectures in the winter session must be diligently attended, no student obtaining a certificate who has not put in three-fourths of a course. The scholarship examinations are held in October.

QUEEN'S COLLEGE, BELFAST.

The total cost of the medical curriculum of the Royal University of Ireland, including examination fees and perpetual fee for the Royal Hospital, but not including fees for the special hospitals, is about £95. If the Conjoint Examination of the Royal Colleges is taken the expense is almost the same.

Clinical instruction is given at the Royal Victoria Hospital. The Union and Fever Hospitals, the Maternity Hospital, the Ulster Hospital for Women and Children, the Hospital for Sick Children, the Ophthalmic Hospital, the Ulster Eye, Ear, and Throat Hospital, and the District Lunatic Asylum are also open to students.

Prizes.—(1) Ten medical scholarships each year, value £20 each; (2) two Dunville studentships (one each year), value £150 each; (3) one Andrews studentship each alternate year, value £140; (4) numerous sessional prizes. A Mackay Wilson Travelling Medical Scholarship will be awarded in 1909.

During the summer session special classes are formed in bacteriology and clinical pathology, and during the winter facilities are afforded to medical men to work at these subjects in the pathological laboratories. From time to time lectures and demonstrations are given in the anatomical department on the Advanced Anatomy of the Nervous System, or some other department of applied anatomy.

A pamphlet containing full information can be had on application to the Registrar, Queen's College, Belfast.

QUEEN'S COLLEGE, CORK.

The arrangements in the Faculty of Medicine are made chiefly with reference to the requirements of the Royal University of Ireland, but students proceeding for the examinations of the Conjoint Boards of England, Scotland, or Ireland, the Society of Apothecaries of London, or the Apothecaries Hall of Ireland, can arrange the course of lectures which they attend, and the order in which they attend them, to meet the requirements of those bodies. Certificates of attendance in the college are also accepted by the University of Cambridge. The total fees for the college lectures and Hospital attendances required by the Royal University of Ireland is about £85.

Clinical instruction is given at the North and South Infirmaries. Students can also attend the Mercy Hospital, the Cork Union Hospital, the County and City of Cork Lying-in Hospital, the Maternity, the Hospital for Diseases of Women and Children, the Fever Hospital, the Ophthalmic and Aural Hospital, and the Eglinton Lunatic Asylum. The winter session commences on October 21st, and ends at the end of April. The courses of the summer session are delivered in the months of April, May, and June.

Scholarships and Prizes.—Eight medical scholarships, two in each of the first four years, of the value of £25 each, and in the fifth year the Blaney Scholarship of the value of about £32, and a Senior Exhibition, value £30. Three Exhibitions, one in practical medicine, one in practical surgery, and one in practical midwifery, each of the value of £15. Book prizes at the sessional examinations.

Further information can be obtained in the College Regulations, or on application to the Registrar, Queen's College, Cork.

QUEEN'S COLLEGE, GALWAY.

Clinical teaching is carried on in the Galway Hospital, established as a Public General Hospital (in the place of the County Galway Infirmary) by Act of Parliament (1892). The Galway Fever Hospital and Galway Throat Hospital are also open to students. The medical lectures are recognised by the Royal University of Ireland and the various Licensing Bodies in the United Kingdom.

Prizes.—There are eight Junior Scholarships in Medicine of the annual value of £25 each. Two are tenable by matriculated students of the first, second, third, and fourth years. The Council has power to award exhibitions for distinguished answering. Sessional prizes are offered in each subject. A Senior Scholarship in Anatomy, value £40, the holder of which is usually appointed Demonstrator, is offered annually for competition, tenable for one year by a student who shall have attended the Medical School of the College for at least two sessions, and shall have obtained a Degree in Arts or Medicine, or a Diploma in Medicine, from a Licensing Body. Scholarship examinations are held at the commencement, and those for Sessional Prizes at the close, of each session.

THE PHARMACEUTICAL SOCIETY OF IRELAND.

The Pharmaceutical Society of Ireland issue two qualifications and a certificate. The qualification of Registered Druggist; the qualification of Pharmaceutical Chemist; and the certificate of competency as Assistant to a Pharmaceutical Chemist.

Registered Druggist.—This qualification entitles the holder to keep open shop for the selling, retailing, and mixing of poisons. In order to obtain it, a person must now have served an apprenticeship or assistantship of four years to an apothecary, pharmaceutical chemist, or to a person who was, or would have been entitled to become, a registered chemist and druggist or a registered druggist, and be 21 years of age. He shall be examined with respect to his knowledge of English orthography and composition, arithmetic, and the weights and measures of the British Pharmacopœia, the appearance and properties of the various drugs and chemicals in general use, and as to the provisions of the Poisons Act. The fee is four guineas.

Examinations in Dublin (also in Belfast and Cork or other place if 12 candidates offer) on the second Tuesday of January, April, July, and October.

Pharmaceutical Chemist.—The qualification of a pharmaceutical chemist in Ireland confers greater privileges than is the case in England.

The subjects of examination are divided between the "Preliminary" and the "Licence."

The Preliminary examination is held on the first Thursday and following day of January, April, July, and October.

The fee is £2 2s. for the first attempt, and 10s. 6d. for each subsequent examination. Further particulars with reference to the subjects for examination may be obtained from the Registrar. The British Society's examination is accepted in lieu of this, as well as those recognised by the General Medical Council as a preliminary to medical studies.

Pharmaceutical Licence Examination.—This examination confers the title of Pharmaceutical Chemist and the right to compound medical prescriptions. Candidates must be 21 years of age, and must have passed the Preliminary prior to the service at practical pharmacy, unless such service was commenced before 1st January, 1907. They must, unless having passed the Preliminary previous to 1884, produce certificates of having served four years as assistant or apprentice to an apothecary or pharmaceutical chemist or four years to a druggist, two years to an apothecary or pharmaceutical chemist, also a certificate of having attended a course of practical chemistry of not less than three months' duration, and of having actually worked at the bench for 100 hours during the said course at a recognised school; and also a course of botany and materia medica. The fee for examination is five guineas, and for re-examination two guineas. Examinations are held in Dublin on the second Wednesday and following day of January, April, July, and October.

Assistant to a Pharmaceutical Chemist.—The examination for the certificate of competency as an assistant may be described, in brief, as the same as that for the Licence, minus the examination in chemistry and botany, with the fee reduced to one guinea (half a guinea on the second and subsequent attempts). The Preliminary examination must be passed as for the Licence, and the usual 14 days' notice must be given. Candidates must have been engaged in practical pharmacy for four years.

Examinations are held on the Monday following the pharmaceutical Licence examination or on such days as the Council may direct.

DEPARTMENT OF AGRICULTURE AND TECHNICAL INSTRUCTION FOR IRELAND.

ROYAL COLLEGE OF SCIENCE FOR IRELAND.

SESSION 1907—1908

This College, situate in St. Stephen's Green, Dublin, supplies a complete course of instruction in science applicable to the industrial arts, especially those which may be cast broadly under the heads of agriculture, chemical manufactures, engineering, physics, and natural science. A diploma of Associate of the College is granted at the end of the three years' course. Non-associate students may join for any course required. There are several entrance scholarships, (*a*) in agriculture, and (*b*) in science and technology, tenable for three years, of the value of £50 each yearly, with free tuition. There are four Royal scholarships of the value of £50 each yearly, with free education, tenable for two years. Two are competed for by the first year associate students at the end of each session. All the laboratories and drawing schools are open daily for practical instruction. The Session commences on Tuesday, October 1st, 1907.

The courses of chemistry, physics, botany, geology, and mineralogy and zoology are recognised by the Royal University of Ireland, and certificates of attendance are granted to medical and other students attending these courses, as also the courses of the chemical, physical, zoological, botanical, and geological laboratories.

The Entrance and Science Scholarship Examinations are held during the first week in July, and the Examinations for Agricultural Scholarships in the first week in September.

THE DUBLIN HOSPITALS.

THE clinical hospitals in Dublin are ten in number exclusive of three lying-in hospitals. There are also two children's hospitals, an orthopædic hospital, a fever hospital, an ophthalmic hospital with two centres, a dental hospital, and other special institutions. Some of the clinical hospitals, though they have no actual or official connection with any school, are in close affinity with certain teaching bodies; while others, again, are without any special connection with any school. While, however, such affiliation of a school or hospital may exist, it should be remembered that the Dublin schools and hospitals are open to all comers, and the student is competent to attend any hospital or any school he wishes, and to change his place of instruction from year to year as he may see fit.

The Irish Licensing Bodies require attendance on hospitals for twenty-seven months, *i.e.*, three winter sessions of six months and three summers of three months, with the five years of study. The fee at all general hospitals is £8 8s. in winter, and for the summer £6 6s., or £12 12s. for the entire session of nine months if taken together.

GENERAL HOSPITALS.

RICHMOND, WHITWORTH, AND HARDWICKE HOSPITALS.—The accommodation at these hospitals is as follows:—Hardwicke Hospital, 120 beds; Whitworth Hospital, 64 beds; Richmond Hospital, 86 beds—total, 270 beds. These hospitals are visited each morning at nine o'clock by the physicians and surgeons, and, in addition to the usual bedside instruction, clinical lectures are delivered on the most important cases. Instruction is also given on various special branches of medicine and surgery. The Truss Establishment, for the distribution of trusses to the ruptured poor of Ireland, is connected with these hospitals. There are large ophthalmic, aural, throat, and gynæcological dispensaries, and instruction in these important subjects is given. Twelve resident clinical clerks are appointed each quarter, and provided with furnished apartments, fuel, &c. The appointments are open not only to advanced students, but also to those who ar qualified in medicine and surgery. A house surgeon for the Richmond Hospital and a house physician for the Whitworth and Hardwicke Hospitals are elected every six months, and receive a salary. The Richmond Lunatic Asylum, containing 1,600 beds, adjoins these hospitals.

MEATH HOSPITAL AND CO. DUBLIN INFIRMARY.—This hospital was founded in 1753, and now contains 160 beds available for clinical teaching. A new building for the isolated treatment of fevers, containing 40 beds, has recently been added. The certificates of this hospital are recognised by all the Universities and licensing bodies of the United Kingdom. Medical and surgical resident pupils and clinical clerks and dressers are appointed every three months, and a house surgeon is elected annually. A prospectus giving the complete arrangements for medical and surgical classes for the coming session may be obtained from the Secretary of the Medical Board, Mr. William Taylor, F.R.C.S., 47, Fitzwilliam Square, Dublin.

THE ADELAIDE MEDICAL AND SURGICAL HOSPITALS occupy a central position within a few minutes' walk of the College of Surgeons and Trinity College. From October 1st, the physicians and surgeons visit the wards and give instruction at the bedside at the advertised hours. There is a large detached fever hospital, and also wards for infants and children. Operations are performed, except in cases of urgency, at 10 a.m. on Tuesday, Thursday, and Saturday. Special hours are devoted to clinical instruction in the diseases peculiar to women, and students are individually instructed in the use of the stethoscope, ophthalmoscope, laryngoscope, and microscope; also special instruction is given on practical pathology and X-ray photography. Two House Surgeons are elected annually and three resident pupils half-yearly. Prize examinations, including examinations for the Hudson Scholarship, £30 and a gold medal, and a senior prize of £10 and a silver medal, in addition to surgical and medical prizes, are held at the termination of the session. The large dispensaries afford facilities for the study of eye, ear, throat, and cutaneous diseases, as well as of minor surgery and dentistry. Further particulars from Mr. Heuston, F.R.C.S.I., 15, St. Stephen's Green North.

THE ROYAL CITY OF DUBLIN HOSPITAL.—This hospital has recently been enlarged and improved to a very considerable extent. A special course of instruction is given on ophthalmic and aural disease. There are special wards for the treatment of diseases of the eye, of children, and of women, and practical instruction is given on diseases peculiar to women; there is also a separate building for infectious diseases. Clinical clerks to the physicians and dressers to the surgeons are appointed from the most deserving of the class. A new operation theatre, sterilising room, and anæsthetic room have been constructed in accordance with the most modern surgical requirements. A Röntgen-ray and light treatment of lupus department has recently been added. A resident medical officer is elected annually, and resident medical and surgical pupils are appointed from among the past and present students of the hospital. Operations are performed on Tuesdays, Thursdays, and Saturdays, at 10 a.m. Special classes for first year students. Full particulars can be had on application to Mr. G. Jameson Johnston, M.B., F.R.C.S.I., Hon. Sec. Med. Board.

SIR PATRICK DUN'S HOSPITAL is situated on the south-eastern side of the city, and about half a mile from the University School of Physic. It is officered almost exclusively by the professors and examiners in that school. Formerly all University students were compelled to attend this hospital, which was purely a medical institution, but some years ago the obligation was removed, and the hospital was opened for surgical cases. It is now free to all students. There is a special wing devoted to fever cases, and regular clinical instruction is given by the members of the medical staff throughout the winter and summer sessions. Special classes for students commencing their hospital studies will be held in the wards during the months of October, November, and December. They will embrace the elements of medicine and surgery, including note-taking. Opportunities are also afforded to students for examining cases of throat, ear, and eye diseases, as well as for performing minor surgical operations and bandaging. In the X-ray Department opportunities are given the members of the hospital class of seeing the various applications of the X-rays to the diagnosis and treatment of injury and disease.

MATER MISERICORDIÆ HOSPITAL.—This hospital, containing 345 beds, is open at all hours for the reception of accidents and urgent cases. Fifty beds are specially reserved for the reception of patients suffering from fever and other contagious diseases. A course of lectures and instruction on fever will be given during the winter and summer sessions. A certificate of attendance upon this course to meet the requirements of the various licensing bodies may be obtained. Opportunities are afforded for the study of the diseases of women in the wards under the care of the obstetric physician, and at the dispensary, held on Tuesdays and Saturdays. Lectures on clinical gynæcology will be delivered on Saturdays at 11 a.m. Ophthalmic surgery will be taught in the special wards and dispensary. A special course of instruction in pathology and bacteriology, as applied to medicine, will be given. Connected with the hospital are extensive dispensaries, which afford valuable opportunities for the study of general, medical and surgical diseases, accidents, &c. Leonard Prizes: One gold and one silver medal will be offered for competition annually in the subject of medicine, and one gold and one silver medal in the subject of surgery. Junior Leonard Prizes: Two prizes of the value of £3 and two prizes of the value of £2 will be offered for competition in medicine and surgery respectively.

MERCER'S HOSPITAL.—This hospital, founded in 1707, is situated in the centre of Dublin, in the immediate vicinity of the Schools of Surgery of the Royal College of Surgeons, the Catholic University School of Medicine, and Trinity College. It contains 120 beds for medical and surgical cases, and arrangements have been made with the medical officers of Cork Street Fever Hospital whereby all students of this hospital are entitled to attend the clinical instruction of that institution and become eligible for the posts of resident pupil, &c. There is a large out-patient department, and a special department for diseases peculiar to women. There are also special wards for the treatment and study of children's diseases. During the past few years the hospital has undergone extensive alterations in order to bring it up to modern requirements. A house surgeon is appointed annually. Five resident pupils are appointed, each for six months, and clinical clerks and dressers are appointed monthly from among the most deserving members of the class. The certificates of this hospital are recognised by all the licensing bodies. For further particulars apply to Mr. R. Charles B. Maunsell, M.B., F.R.C.S., 32 Lower Baggot Street, Dublin.

ST. VINCENT'S HOSPITAL was established in 1834, it has 160 beds, and in connection with it there is a largely-attended dispensary, a convalescent home, and a nurses' institute. In addition to the ordinary clinical instruction, systematic courses of lectures are given in each department of medicine and surgery, and are illustrated by cases in the hospitals. The resident officers consist of a house surgeon, a house physician, and four resident pupils. Three clinical lectures are delivered daily in the wards, illustrated by selected cases, and beginning at 9 a.m. Two gold medals and other valuable prizes and certificates of merit are awarded at the end of each session. A prospectus can be had from Dr. Dargan, 45, Stephen's Green, East Dublin.

DR. STEEVENS' HOSPITAL, situated at Kingsbridge, is the oldest and one of the largest clinical hospitals in Dublin, and contains over 200 beds. A very fine Nurses' Home was recently added to the institution, with accommodation for over seventy nurses. A new and thoroughly equipped dispensary and out-patient department has been completed and opened to patients. There is accommodation for twelve resident pupils—four medical, six surgical, and two in the special departments, each of whom is supplied with a separate room. All information with regard to these appointments can be had from the Resident Medical Officer at the hospital. Licensing bodies recognise six months' residence as equivalent to a year's ordinary attendance at hospital. The manufactories and railway works in the neighbourhood supply this hospital with large numbers of accidents and other cases, while the special ward for venereal diseases affords exceptional opportunities for the study of this important subject.

Jervis Street Hospital is the oldest established in Dublin. The new hospital was completed in 1896, since which time it has been open for the reception of patients. In addition to large medical and surgical dispensaries, the out-patient department includes special departments for the treatment of diseases of the skin, eye, ear, and throat, and diseases peculiar to women. Two resident surgeons are appointed annually. Clinical clerks and surgeons' dressers are selected from among the most attentive of the advanced students without the payment of any additional fee. Twelve interns are appointed annually, and are provided with apartments, &c., free of expense. Special certificates are given to resident pupils and dressers who have performed their respective duties to the satisfaction of the physicians and surgeons.

Students of Jervis Street Hospital are entitled to attend free of charge the Children's Hospital, Temple Street, which contains 100 beds, and where special lectures are given on Diseases of Infancy and Childhood, and on Orthopædic Surgery and appliances, and to obtain special courses in fevers at Cork Street Fever Hospital.

Students of other Hospitals are admitted as residents when vacancies occur.

Terms: £2 2s. per month, or £5 5s. for three months, exclusive of board.

SPECIAL HOSPITALS.

The special hospitals of Dublin are the Rotunda, the Coombe, and the National Lying-in-Hospitals, Cork Street Fever Hospital, the Royal Victoria Eye and Ear Hospital (amalgamation of St. Mark's Ophthalmic Hospital and the National Eye and Ear Hospital), the Dental Hospital, the Throat Hospital, the Orthopædic Hospital, the Children's Hospitals in Harcourt Street and in Temple Street, and the City Hospital for Diseases of the Skin.

The Rotunda Hospital.—This institution is the largest, the longest established, and the most famous gynæcological as well as maternity hospital in the British Empire. The work performed by it is about three times greater than that of any other hospital of its kind in Ireland. The number of patients admitted to the hospital, and also attended in the extern maternity has increased enormously within recent years. The routine daily work comprises the attendance of lectures on midwifery and gynæcology; practice in abdominal palpation; personal conduction of parturition both in the extern and the intern maternities; cystoscopic examinations, as well as attendance at the operation work of the hospital. The hospital affords exceptional advantages to qualified men who take out a three months' course during the autumn, winter, and spring months, for they (if considered competent) are permitted a certain amount of practical operation work, viz.—forceps, curettings, perineorrhaphy, &c. Students are liable to summary dismissal without refund of fees for gross misconduct, or serious breach of the hospital rules. A special afternoon class in gynæcology is held by the Senior Assistant, £2 2s. per month. The Pathological laboratory under the direction of Dr. Rowlette has become an important feature of the hospital. Students can enter at any time for periods of one month or longer. Certificates of attendance are accepted by all the licensing bodies. The L.M. certificate is obtained by attendance at the hospital for six months, with the subsequent passing of an examination. A special certificate in gynæcology is presented to students whose work meets with the Master's approval. Paid clinical assistants are selected (from among those who have obtained the hospital L.M. certificate) by competitive examination, for periods of six months. The residents' quarters have undergone complete renovation and now afford comfortable accommodation. The grounds of the hospital contain asphalt and grass courts for lawn tennis and croquet. There is also a full-size billiard table.

Fees for Pupils.—Intern:—One month, £6 6s.; two months, £9 9s.; three months, £12 12s.; six months, £21; single months other than the first, £4 4s; board and lodging in the house per week, £1 5s. Night students (not resident in house), £6 6s. for first three months; £4 4s. for the second three months. For further particulars apply to E. Hastings Tweedy, Master, Rotunda Hospital, Dublin.

Coombe Lying-in Hospital.—This hospital consists of two divisions, one of which is devoted to lying-in cases, and the other to the treatment of diseases peculiar to women. The practice of this hospital is one of the largest in Ireland; nearly 18,000 cases are treated annually, either as intern or extern patients. Lectures are delivered, practical instruction is given, and gynæcological operations are performed in the theatres daily. There is a general dispensary held daily, at which instruction is given on the diseases of women and children. There is a special afternoon dispensary held by the Master and his assistants, at which practical instruction in gynæcology is given. This is the largest dispensary of its kind in Dublin. There is no extra charge for attendance at this dispensary. There is accommodation for a number of qualified and unqualified intern pupils, who enjoy exceptional advantages of acquiring a thorough knowledge of this branch of their profession. Lady medical students can reside in the hospital. Clinical assistants are appointed from among the pupils as vacancies occur. Certificates of attendance at this hospital are accepted by all licensing bodies, and the diploma is recognised by the Local Government Board as a full legal midwifery qualification. The residents' quarters have been much enlarged. A billiard table has been erected for the use of students. Extern pupils pay, for full course of six months, £8 8s. Intern pupils pay one month, £4 4s.; six months, £18 18s. Board and lodging in the hospital, 18s. per week. Lady students' intern pay for one month, £5 5s.; each consecutive month, £4 4s.

* **National Maternity Hospital.**—This institution, under the mastership of Dr. Barry and Dr. A. Horne, is situated in Holles Street.

Cork Street Fever Hospital is the only special fever hospital in Dublin. It is supported mainly by subscriptions, an annual Government grant, and capitation grants for patients. Regular clinical instruction is given during the winter and summer sessions to those who desire a special course in fevers. There are also courses for the Diploma in Public Health. All particulars may be obtained on application to the Medical Superintendent.

The National Children's Hospital for the treatment of all non-infectious diseases peculiar to children, with which the Pitt Street Children's Hospital, founded in 1821, was amalgamated, is capable of containing 50 beds for the reception of cases of deformity and all other forms of surgical disease. There is a large general dispensary for extern patients held daily from 10 to 11. Operations are performed on Saturday at 12 o'clock. Practitioners and students can attend on application to Sir Lambert H. Ormsby, F.R.C.S.I.

***The Children's Hospital, Dublin** (under the care of the Sisters of Charity).—This institution is one of the most progressive and up-to-date children's hospitals in the Kingdom, besides being the largest in Ireland. There are 100 beds available for patients; about 1,000 cases are admitted to the wards annually; and about 7,000 or 8,000 seen in the dispensary. During the last year a new operating theatre has been opened. It is fitted and furnished in the best possible fashion for present-day surgery. Special attention is given to orthopædic surgery, and the number of deformities from all parts of Ireland treated and cured in the hospital is rapidly increasing. A special masseuse has been appointed to the hospital to aid in this department.

The hospital is recognised for clinical instruction in the diseases of children by the R.U.I. and licensing bodies, which require a certificate of instruction in this important branch of medical education. A nursing home is in connection with the institution, and trained nurses are always available for private cases. Senior students or others requiring a post-graduate course at the hospital should apply for full particulars to M. C. Staunton, hon. sec., or to any member of the staff.

The Incorporated Orthopædic Hospital, Ireland.—This hospital was founded in 1876, and contains 80 beds. It is available for every class of deformity available for treatment. Particulars may be obtained from Captain Borthistle, Registrar, at the hospital.

The Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin.—This hospital, which was opened in March, 1904, is an amalgamation of St. Mark's Ophthalmic Hospital and the National Eye and Ear Infirmary. The hospital contains 80 beds. Clinical instruction in diseases of the eye and ear, including the use of the ophthalmoscope and operations, is given daily from 10 till 1. Special classes for practical instruction in the use of ophthalmoscope, &c., and for the demonstration of cases, are formed from time to time.

The Incorporated Dental Hospital, Lincoln Place.—This hospital, recently erected, is the only special Dental Hospital in Dublin. It is officered by a very strong staff of the leading dental surgeons of Dublin, and has a large *clientèle* and extensive practice among the Dublin poor. The fees are £15 15s. for the first year's study, and £12 12s. for second, and proportionately smaller fees for shorter periods.

The City Hospital for Diseases of the Skin and Cancer, Great Brunswick Street.—The first and only one of its kind in the city was the first in Ireland to instal the Finsen treatment. Senior students are admitted free to the practice of this hospital, which has a large daily out-patient attendance, with 15 beds available for the admission of acute cases. Classes of instruction will be given at regular intervals during the winter and summer sessions in the use of the Finsen light, X-rays, high frequency currents and radium, with demonstrations on (1) the production and use of the Röntgen rays, (2) electric currents, direct and alternating, with description of resistances, rectifiers and transformers; (3) accumulators, their construction, use, and methods in charging; (4) vacuum tube, choice of tube for particular kinds of work. Fluorescent screen, and how to localise foreign bodies.

BELFAST HOSPITALS.

* Hospital for Sick Children, Queen Street.—This institution, erected by voluntary donations, and supported by voluntary contributions, was opened for the reception of patients on April 24th, 1879. The hospital consists of a medical ward with twenty-eight beds, and one of a similar size for surgical cases. It is strictly non-sectarian in its principles, and is open to all denominations. Children from birth to the age of 12 years, and not suffering from contagious disease, are admissible as in-patients. A very large extern is conducted in the out-patient department between the hours of 9 and 10 a.m., where children from birth to 14 years are attended to. The convalescent home, which is situated at Newtownbreda, contains thirteen cots, and its situation and equipment render it an admirable adjunct to the after-treatment of the cases admitted to the hospital. During the winter session systematic courses of lectures and demonstrations in the medical and surgical diseases of infancy and childhood are delivered in the wards on Wednesday and Friday of each week at 9 a.m.

* Mater Infirmorum Hospital.—Established 1883. 160 beds. The New Mater Hospital, which was erected at a cost of over £50,000, was formally opened on April 23rd, 1900. During the year the intern patients numbered 1,525; accidents, 3,762, and cases treated in the Dispensary, 22,597; 389 surgical operations were performed with the most satisfactory results. The total number of patients who received treatment was 27,884, being an increase of 1,517 as compared with the year 1904. A notable feature is in the number of accident cases, as the hospital is conveniently situated in proximity to a large working-class population, and within easy reach of most of the public works.

The Belfast Maternity Hospital (Incorporated).—Established 1794. 30 beds.—The practice of the Maternity Hospital, the certificate of which is recognised by the Royal University, &c., &c., is open to students. The fee for the session is £2 2s. Resident nurses are also received for training for a period of six months, and a diploma given which is recognised by public bodies. Conditions for such on application to the Matron. During the year 1906, 373 patients were treated in the hospital, and 310 patients at their own homes. Besides this, 177 patients were dealt with in the extern gynæcological department. Clinical lectures and bedside demonstrations are given by members of the staff during both the winter and summer sessions. Students wishing to attend should apply to Dr. H. D. Osborne, 32 Lonsdale Terrace, Belfast, Hon. Secretary to Medical Staff, on or before November 1st and May 1st.

Note.—Hospital was rebuilt in 1904 and removed to splendidly equipped new premises in Townsend Street. A Resident Surgeon elected periodically.

Ophthalmic Institution and Eye and Ear Hospital, Great Victoria Street, Belfast.—Established 1844. New hospital erected, 1867. New extern department and operation theatre added, 1902. This hospital is situated on the main road between Queen's College and the Royal Victoria Hospital. It contains about 30 beds for intern patients, and a large extern department. The latter is open on Monday, Wednesday and Friday at noon for eye cases, and on Monday and Thursday at noon for ear and throat cases. Special courses of instruction are given during the winter and summer sessions, but students can enter at any time, and can always obtain plenty of practice in ophthalmoscopic work. Full particulars may be had from Dr. Cecil Shaw, 18 College Square East, Belfast.

Royal Victoria Hospital.—Established 1791; incorporated by Royal Charter, 1875 and 1898. New hospital opened, September 17th, 1903. 300 beds; Convalescent hospital, 24 beds; Children's Hospital, 33 beds; Consumptive Hospital, 10 beds.

Ulster Eye, Ear, and Throat Hospital.—Established 1871. New hospital opened 1874. 30 beds.

Ulster Hospital for Children and Women, Mountpottinger, Belfast, is the only hospital in the large part of the city situated on the County Down side of the river. It is placed in a working class district, and has a great field for its charitable operations. There are in the hospital about twenty-two beds for children and eight for women. There is an extern department for children open every week-day, except Saturday, from 9 till 10, and for women at 11.30, and a special department for diseases of the eye, ear, and throat on Tuesdays and Fridays from 9 till 10. During the summer and winter sessions, clinical instruction is given to students daily, operations being chiefly performed on Wednesday and Saturday. There is a resident midwife for extern work, and every facility is afforded students for attending their cases in the district.

CORK HOSPITALS.

Victoria Hospital for Women and Children.—Established 1874. 70 beds. An immense amount of work is done in this hospital to relieve the poor of Cork, Kerry, and other counties. A large number of successful operations are done every year. The hospital contains several very fine private rooms for paying patients.

* County and City of Cork Lying-in Hospital.—Established 1798. 17 beds.

* Eye, Ear, and Throat Hospital, Western Road.—Incorporated 1898. 35 beds. Inpatients treated during year, 454; outpatients, 4,238. Clinical In-

struction is given during college session. Special demonstrations in the use of the ophthalmoscope, larynogscope, &c., are given from time to time.

* **Fever Hospital and House of Recovery.**—Established 1801. 110 beds.

* **Maternity.**—Established 1872.

* **Mercy Hospital.**—Established 1857. 80 beds.

* **North Charitable Infirmary.**—Established 1774 110 beds. Special wards for treatment of diseases of women and children. The extern department is largely availed of, and the number of accidents treated is very large. Clinical instruction is given daily from 9.30 a.m. to 12 noon. A new and thoroughly up-to-date operating theatre has recently been added at enormous expense.

Cork South Infirmary and County Hospital.—Founded 1773. The hospital contains 100 beds, available for clinical instruction, 40 medical and 60 surgical. There are also special wards devoted to the treatment of diseases peculiar to women and children, and a large medical and surgical extern department.

Clinical instruction is given daily during the session from 9.30 to 11.30, in both the medical and surgical wards, and clinical lectures are regularly delivered.

The operation and sterilising rooms are thoroughly up to date. The X-ray department is fully equipped with the newest apparatus necessary for such work. Students are regularly instructed in the methods of using the rays by practical demonstration on the cases requiring their use.

The hospital has been largely availed of by students of the Cork School of Medicine.

GALWAY HOSPITALS.

* **County Hospital.**—Established 1786. 60 beds.

* No answer to our request for information received from these hospitals.

IRISH PUBLIC SERVICES.

The Poor-law Medical Service.

For several years past the unsatisfactory nature of the Irish Poor-law Medical Service, as a career for young practitioners, has furnished a theme for the opening addresses at all the leading medical schools. In addition to the petty annoyances, the laborious and harassing duties, and the ever-increasing amount of clerical work which the new orders of the Local Government Board impose from time to time, the unfortunate medical officers are grievously underpaid, their salaries being totally out of proportion to the duties discharged, and in the majority of rural districts barely sufficent to cover the out-of-pocket expenses, such as are incurred in the keep of a horse and man, and other servants. The Local Government Board have recently laid it down, moreover, that the dispensary patients have the first call on the time of the medical officer, and that, even if he is engaged on an urgent private case, he must give it up and go off to attend on a scarlet-runner, as the dispensary visiting tickets are not inappropriately called. So strictly is he bound up to the discharge of his duties that unless incapacitated by sickness or other cause, or with the permission of the guardians expressly granted, he cannot leave his district for a single day, even if he makes provision for the performance of his duties in his absence by a brother practitioner. The Irish Medical Association, whose work includes the safeguarding of the interests and the improvement of the condition of the Poor-law medical officer, considers it an imperative duty to point out to young practitioners the following facts: (1) That the Poor-law Medical Service is one in which there is no promotion. (2) That it is a service where few facilities exist for original research, and still less for further medical culture, especially in the rural districts. (3) That, while medical education has become wider in its requirements, and more costly and difficult to procure, almost the same rate of payment given to less educated men forty years ago is still offered, and this, too, at a time when the rural prosperity of the country is less, and consequently lucrative private practice more difficult to obtain. (4) That there is no compulsory superannuation, and, as a consequence, many old and infirm doctors are forced to remain on in the service long after they have become unfit to discharge the duties, seeing nothing but extreme poverty and perhaps the workhouse itself staring them in the face.

We need go no further than to say that the Irish Poor-law Medical Service is a service to avoid. We therefore strongly urge on young medical men the importance of supporting the interest of the profession by refraining from applying for vacant posts of which the salary is insufficient, from accepting posts as *locum tenens* at a lower rate than £4 4s. per week.

There are 159 workhouses and about 810 dispensary medical officers, besides apothecaries. The number of vacancies that occur annually averages 100. The salary in this service used to average about £114, but is rapidly coming down, and when it is taken into consideration that in the vast majority of rural districts it is necessary to keep one or more horses, the average area being from forty to sixty square miles, it is plain that there will not be a large margin left from the public emoluments.

The medical officer is also *ipso facto* the registrar of births, marriages, and deaths, and medical officer of health for the district, under the Public Health Act, passed in 1873 and amended in 1878. The former office, in country districts, yields between £5 and £10 a year. and the emoluments of the latter appointment in very few cases reach £20, averaging about £12. The medical officer is also vaccinator for the locality, and is required to vaccinate everyone who wishes to come. For each patient a fee of 2s. is paid, along with his salary, by the guardians, and the sum total of those fees varies, according to the populousness of the district, from £4 to £100, an average for the provinces being about £10.

Qualifications.—The qualifications required by the Local Government Board are a licence in surgery, in medicine, and in midwifery; but registration in the "Medical Register," if effected since the passing of the Medical Act, in 1886, fulfils all requirements. The candidate must also be 23 years of age.

Duties.—The duty of the dispensary doctor is two-fold. He has to attend his dispensary on a given day or days in the week. Frequently there are two dispensaries in the district, separated from each other by several miles, and he will have, perhaps, to attend two days a week. He has also to visit at any hour of the day or night a sick person for whose relief a visiting ticket has been issued by a guardian, warden, or the relieving officer, and to continue his attendance as often as may be necessary to the termination of the case. Moreover, he has a great many registry books to keep and a multitude of returns to make, and in many districts he has to make up all the medicines for the poor.

Workhouse Hospitals.—The number of unions in Ireland is 159, to each of which is attached a medical officer, who is appointed and controlled by the board of guardians in the same manner as the dispensary medical officer. The salary is usually better than that of the dispensary doctor, and the duties of a more easy and satisfactory description, inasmuch as they are confined to daily attendance at the workhouse hospitals, and no night visits out of doors or long journeys across the country are involved.

The Irish Lunacy Service.

This service, at present, affords a comfortable livelihood for 22 Resident Medical Superintendents and 32 Assistants. The Superintendents receive salaries and allowances ranging, according to the number of inmates of the asylum, from £500 to £1,000 a year, and the Assistants receive salaries and emoluments averaging about £200 a year. There are also Visiting Physicians receiving about £120 a year, but this class of officer is being allowed to die out, and no new appointments will be made. The Superintendents and Assistants must devote their whole time to their duties.

Heretofore the appointments of Medical Superintendents have been in the patronage of the Lord Lieutenant, but, under the Local Government Act, they are in the hands of the County Councils, with the proviso that no one shall be appointed who is not a fully registered practitioner with five years' service as Assistant. The Assistant is appointed by the Committee of the County Council to which the management of the the asylum is entrusted. In addition to these officers, there are, in certain larger asylums, Clinical Residents, who receive about £50 a year and full allowances. These appointments afford excellent introduction to the higher places in the service.

OTHER APPOINTMENTS.

There are, in addition to those which we have mentioned, certain appointments open to medical practitioners in special localities. They are :—

(1) Attendance on the Royal Irish Constabulary. (2) Attendance on the Coastguards. (3) Factory Surgeoncies. (4) Attendance upon the depôt soldiers who are not otherwise provided for.

The Constabulary are paid for at the rate of 2s. per month for each member of the force on duty in the district, including the wives and children of the men, but not of the officers. This includes the supply of medicines. The appointment to this position rests with the Inspector-General of the Royal Irish Constabulary, who usually acts upon the advice of the local District Inspectors as to the convenience of the men, and, of course, the emoluments depend on the number of Constabulary stations and the number of men in each.

The Coastguard Service.—The duty of the Medical Officer is to attend the men when sick and to examine candidates either for admission or for superannuation. The fees vary from 5s. to 2s. 6d. per visit. The appointments rest with the Admiralty, but are usually secured for the local Poor-law Medical Officer. The emoluments depend on the number of stations and men.

Factory surgeoncies are in the gift of the Chief Inspector of Factories in Whitehall. There is a set scale of payment by the factory owner to the inspector for this work, but we believe it is not adhered to, and, in some districts, at all events, the emolument is a matter of arrangement. The amount depends upon the size of the factory, the position being, in Dublin or Belfast, or in other large manufacturing centres, a lucrative one, but in other places scarcely worth taking. The attendance on the military depôts is not worth mentioning.

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Death of Mr. Timothy Holmes.

THE death of Mr. Timothy Holmes, F.R.C.S., will form a matter of regret to all old Cambridge and St. George's men, as well as to a large circle of other members of the profession. Mr. Holmes, who was over eighty years of age, graduated as Bachelor of Arts, at Cambridge, as far back as 1847, and afterwards entered as a student at St. George's. He became a Fellow of the Royal College of Surgeons in 1853, and was soon afterwards appointed assistant surgeon to the hospital. He was for a long period full surgeon, and on retirement he was appointed consulting surgeon and joint-treasurer. For many years he was chief surgeon to the Metropolitan Police, and he had been president of the Royal Medical and Chirurgical and of the Pathological Society, as also vice-president of the Royal College of Surgeons, and Hunterian Professor of Surgery and Pathology to the College. His surgical writings have been numerous and valuable, including, besides many detached papers and articles, important contributions to a "System of Surgery," of which he was editor.

Scotland.

NOTWITHSTANDING the increased competition which the recent vigorous growth of the great English provincial medical schools, added to the unsurpassed attractions of the historic Metropolitan hospitals, with their staffs of renowned teachers, ensures, the Scottish medical schools seem fully to retain their popularity, not only, as is natural, among Scotsmen and their colonial descendants, but among medical students from England, Wales, and Ireland, and, indeed, all parts of our Empire. And undoubtedly the competition of other centres has had the advantage of making Scottish teachers bestir themselves, with the result that the efficiency of the medical schools is now much greater than a decade ago. The advantages derived from the second half of the Carnegie Bequest, *i.e.*, the improved equipment of the teaching schools and the encouragement of post-graduate research are proving potent factors in promoting the well-being of the Universities and Scottish education generally. Of the four universities, Edinburgh, of course, occupies the premier position as a medical school, but at Glasgow, Aberdeen, and St. Andrews, an almost equally good—indeed, in individual details, better—training can be obtained. Two ordinary qualifications to practise are granted in Scotland—the M.B., Ch.B. of the Universities, and the triple qualification of the Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow. The examinations for the University degree naturally are more exacting than those for the triple qualification, and the curriculum wider. Nevertheless, the standard for the latter is much higher than formerly, though on account of the large number of examiners in most subjects it is probably slightly less uniform than that of the universities, where the examinations are conducted by the professors with one or more extra-mural assessors in each subject. Two features of the Scottish system deserve mention—first, as regards the co-ordination of various separate teaching bodies in each centre ; second, as regards the conditions under which the students live. Around each university there has grown up an extra-mural medical school, in which the teachers are hospital physicians, surgeons, and specialists unconnected with the university, but whose classes qualify for graduation. Thus the student has usually ample choice, and can, within certain limits, attend the teacher from whom he thinks he will derive most benefit, while the extra-mural lecturers, being unendowed and constantly recruited by fresh blood, have a permanent incentive to keep their courses up to the mark, since any slackness is at once followed by a diminution in the number of students' fees. In late years instead of each extra-mural teacher lecturing separately, combinations have been formed, in which different parts of a course on medicine are given by different physicians, and these have proved exceedingly popular and successful. A very important part of the student's clinical work, too, is done at institutions and under teachers quite unconnected with the universities ; this is his dispensary practice, which may be taken at one of several dispensaries situated in the poorer districts of the towns. Until recently, practical training in obstetrics was one of the least satisfactory parts of the teaching in Edinburgh, and many students were in the habit of going to Glasgow or Dublin for their maternity work. Recently, however, steps have been taken which should render this unnecessary, and ought to give Edinburgh students quite sufficient opportunity of acquiring as good a practical acquaintance with this most important subject as they have of obtaining a theoretical knowledge of it. From what has been said it will be seen that university undergraduates and triple qualification men rub shoulders at every turn—in the wards, dispensary, and lecture-room. University students have the privilege of studying under both intra- and extra-mural teachers, while men going up for the triple qualification are limited to the latter. It is not uncommon, therefore, for a man to come up intending to take the licence, and to change his mind and go in for a degree, or *vice versâ*; and this can usually be done without much added expense or taking out many fresh classes, provided the change is not made too late in the curriculum. The weak spot in the Edinburgh curriculum is the overcrowding of subjects in certain years, but the new three-term session, with the increased frequency of professional examinations, which comes into operation on October, 1907, will do much to remedy this, and make the course more elastic.

For the rest, the student lives as he likes and where he likes; the authorities only demand that he shall attend classes with due regularity and diligence, and exhibit sufficient proficiency to pass his examinations. Most men live in lodgings, a few board with private families, and some live in the various halls of residence which have been established. In these last, too, the student is his own master, the halls being managed solely by a committee of the residents for the time being. It is impossible to make any very definite statement as to the relative cost of a medical education in the different schools, as compared with London and Dublin, as so much depends on the extra classes taken out, the mode of living, and so on. The minimum inclusive fees for the licence are £120, for the M.B. degree about £146; but almost every student finds it practically necessary to attend additional classes. On the whole, the cost of living is highest in Edinburgh, lowest in Aberdeen; in the former, while the rent of lodgings is lower than in London, maintenance, including clothing and provisions, is somewhat more expensive. Incidental expenses, amusements, &c., are, however, considerably less in the Northern capital. In Aberdeen, money goes much further than in the south, and the student ought to keep himself on about two-thirds of the funds required in Edinburgh.

THE CARNEGIE TRUST.

Through the munificence of Mr. Andrew Carnegie, LL.D., payment is now made "of the whole or part of the ordinary class fees exigible by the Universities from students of Scottish birth or extraction, and of sixteen years of age or upwards, or scholars who have given two years' attendance, after the age of fourteen years, at State-aided schools in Scotland, or at such other schools and institutions in Scotland as are under the inspection of the Scottish Education Department."

The Trust provides for the payment of the class fees of the above students proceeding to graduation in medicine or science. Application for payment of class fees under the conditions of the Trust should be made to the Secretary, Mr. W. S. McCormick, Merchants' Hall, Hanover Street, Edinburgh.

UNIVERSITY OF EDINBURGH.

Four degrees in medicine are granted: Bachelor of Medicine (M.B.), Bachelor of Surgery (Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). The first two must be taken together, the last two may be taken separately.

No one is admitted to the degrees of Bachelor of Medicine and Bachelor of Surgery who has not been engaged in medical and surgical study for five years, after passing a preliminary examination in general knowledge in accordance with the medical ordinances. A degree in Arts or Science of a British or other recognised University is held to supersede such preliminary examination. The subjects included in this general examination are English grammar and composition, English history and geography, Latin, arithmetic, and the elements of mathematics, and Greek, or French, or German.

The *annus medicus* of each year is constituted by at least two courses of not less than one hundred lectures each, or by one of such courses, and two courses of not less than fifty lectures each, exclusive of the clinical courses. Two years of the five must be spent at the University, the remaining three years at any other Medical School recognised by the University Court.

During the first four years the student must attend botany, zoology, physics, practical chemistry, practical physiology, practical pathology, and medical jurisprudence during courses of not less than 2½ months each; public health, not less than forty lectures; practical anatomy, during two courses of not less than five months each; chemistry, anatomy, physiology, pathology, surgery, materia medica, medicine and midwifery during courses of not less than five months each. He must attend a course of twenty-five lectures on practical pharmacy, or have dispensed drugs for a period of three months in a recognised hospital or dispensary. He must attend a nine months' course in clinical medicine and in clinical surgery. During the fifth or final year he must be engaged in clinical study for at least nine months. In all, before graduation, he must have done hospital work for at least three years, and have acted as clerk in the medical and surgical wards and attended for six months the practice of a dispensary, or of a physician and surgeon. He must also have studied (1) operative surgery; (2) mental diseases; (3) *post-mortems*, fevers, and diseases of the eye, and (4) one of the following. Diseases of children, of the ear, nose and throat, or of the skin; (5) vaccination.

He must attend at least twelve cases of labour under the superintendence of a registered medical practitioner or six such cases, and, for at least three months, the practice of a midwifery hospital.

Each candidate is examined both in writing and *vivâ voce* —

1. On zoology, botany, physics and chemistry.
2. On anatomy and physiology.
3. On pathology, and materia medica and therapeutics.
4. On medicine, surgery, midwifery, forensic medicine, and public health.

On October 1st, 1907, a new division of the medical curriculum will be inaugurated, the year being divided into three sessions, a 1st winter, a 2nd winter, and a summer session. At the end of each of these professional examinations will be held, instead of twice yearly as at present. This will admit of some re-arrangement of classes, pathology being taken before materia medica, instead of concurrently or subsequently, as at present.

The new order of examination will be as follows:— Physics, end of first half of first winter session; Chemistry, end of second half of first winter session; Zoology and botany, end of first summer session; Physiology, end of second summer session; Anatomy, end of first half of third winter session; Practical materia medica, end of second half of third winter session; Pathology, end of third summer session; Materia medica, end of second half of fourth winter session; Medical jurisprudence and public health, end of fourth summer session; Midwifery, end of first half of second winter session; Medicine and surgery, end of second half of second winter session; Clinical medicine, surgery and gynæcology, end of fifth summer session.

The degree of Doctor of Medicine may be conferred on any Bachelor of Medicine and Bachelor of Surgery, and who is of the age of twenty-four years, and who produces a certificate of having been engaged, subsequently to his having received the degrees of M.B. and Ch.B., for at least one year in attendance on a hospital, or in scientific work bearing directly on his profession, or in the military or naval medical services, or for two years in practice other than purely surgical. The candidate shall submit to the Faculty of Medicine a thesis on any branch of knowledge comprised in the professional examinations for the degrees of Bachelor of Medicine and Bachelor in Surgery. The candidate will also be examined in clinical medicine and must show practical acquaintance with advanced methods of diagnosis; he *may* take, at option, gynæcology, mental diseases, or diseases of children for one of his three cases. The degree of M.D. is conferred on holders of the degrees of M.B., C M. (Old Regulations) on the submission of a thesis approved by the Medical Faculty, provided that the candidate shall have passed the preliminary examination in the subjects of Greek and logic or moral philosophy. Should the candidate elect to do so, he may, however, take the M.D. degree under the new regulations, *i.e.*, substituting an examination in clinical medicine for that in Greek and logic. This course is usually pursued by those who did not pass in these subjects with the rest of their preliminary examinations.

The regulations for the degree of Ch.M. are very similar.

Fees :—The fee to be paid for the degrees of Bachelor of Medicine and Bachelor of Surgery is twenty-two guineas. The fee for the degree of Doctor of Medicine or of Master of Surgery is ten guineas (Old Regulations, £5 5s.).

The total expense of the curriculum, including examination and matriculation fee, is £146.

Among scholarships, &c., open for competition during the session 1907-8 are the following :—Vans Dunlop scholarship, value £100, in chemistry, anatomy and physics, in botany and zoology, and in physiology and surgery. Stark scholarship in clinical medicine, value £110 ; Buchanan scholarship in midwifery, value £40 ; Mouat scholarship in practice of physic, £57. Mackay Smith scholarship in chemistry, value £25. A Creighton research scholarship (anatomy and physiology) £100. Houldsworth scholarship, re-search in pharmacology,£49; McCunn medical research scholarship, £100. There are also a great many other bursaries Fellowships, and prizes open during the session 1907-8, and for the details governing entry for these the University Calendar (James Thinn, South Bridge, Edinburgh) should be referred to.

Graduation in Public Health: Degrees (B.Sc. & D.Sc.) are also conferred in Public Health. Candidates must be graduates in medicine and must matriculate for the year in which they proceed for examination. They must (1) have worked at least twenty hours a week during a period of not less than eight months in a recognised Public Health laboratory—five of these months must be spent consecutively in the Public Health Laboratory of the University of Edinburgh; and (2) have attended a course of lectures on physics in addition to that qualifying for graduation in medicine, and one on geology.

Candidates for the second examination are not admitted until at least eighteen months have elapsed after having passed M.B., Ch.B., or sooner than six months after the first examination. They must have attended two courses of Public Health, one dealing with medicine, the other with engineering, in relation to public health. They must also have studied practical sanitary work under a Medical Officer of Health for six months, have had three months' clinical instruction in a fever hospital, and three months' instruction in mensuration and drawing.

Fees for Science Degrees : B.Sc., first examination, £3 3s. ; B.Sc., second examination, £3 3s.

Diploma of Tropical Medicine.—Every year an increasing number of candidates avail themselves of the University Diploma of Tropical Medicine and Hygiene, which is conferred only on those possessing a degree in medicine. The course includes practical bacteriology, diseases of tropical climates, tropical hygiene, the zoological character and life history of disease-carrying insects and venomous animals, clinical instruction at an hospital for tropical diseases. The examination is held in January and July, the fee being £4 4s.

University Hall, Edinburgh.—In an educational number it is worth while to call attention to the advantages now offered to students coming to Edinburgh to study, in the shape of social residences, in which students can live in a self-governing community. In each house there are private studies with or without bedrooms, and common sitting and dining rooms. The charges vary from 7s. 6d. to 22s. 6d. per week. The residents elect a treasurer from among their number who acts as intermediary between them and the housekeeper or servants. It is a satisfactory indication of the comfort of the Hall that many graduates live in it and are willing to help or coach the undergraduates for moderate fees. To gain admission two references must be produced from past or present residents, or other suitable person. These are considered and voted on at a house meeting. The Hall is an admirable place for parents to send their sons to. Any unruly member may be expelled by a meeting of the residents similar to that held for elective purposes.

Medical School for Women.—The medical teaching of women in Edinburgh is carried on by the Scottish Association for the Medical Education of Women (the Secretary, Minto House, Chambers Street). The classes are conducted by the lecturers of the Medical School of the Royal Colleges, and qualify both for the Edinburgh University degree and for the Licence of the Triple Board. The classes are for women alone. The University of Edinburgh does not recognise certificates presented by female candidates for mixed classes without special cause shown. Women students are eligible for the benefits of the Carnegie Bequest.

UNIVERSITY OF GLASGOW.

The University of Glasgow is both a teaching and an examining body, but admits to examination only those candidates whose course conforms to its own regulations. Within certain limits provision is made for accepting instruction given by recognised medical schools and teachers; but eight of the subjects other than clinical must be taken in this or some other recognised University entitled to confer the degree of M.D., and at least two years of the course must be taken in Glasgow University. Under the new regulations, laid down in Ordinance No 14, Glasgow No. 1, of the Commissioners under the Universities (Scotland) Act, 1889, four degrees, open both to men and to women, are conferred—M.B. and Ch.B. (always conjointly), M.D. and Ch.M. A preliminary examination must be passed in (1) English, (2) Latin, (3) Elementary mathematics, and (4) Greek, French, or German, with possible option to students whose native tongue is not English in the case of the fourth subject, and, on passing, students must register in the books of the General Medical Council. By a regulation recently enacted, it is no longer compulsory to pass in all the four preliminary subjects at once, and they may now be passed at two stages. For M.B. and Ch.B. a curriculum of five years is required. A syllabus with full details of the curriculum and of the preliminary examination may be had, post free, on application to the assistant clerk, Matriculation Office.

The fees for M.B. and Ch.B. are £23 2s. ; for M.D. £10 10s., and for Ch.M. £10 10s. For hospital attendance there is an initial fee of £10 10s., with a further fee of £3 3s., for each winter session, and £2 2s. for each summer session of clinical instruction. There are three very extensive general hospitals in the city, which afford exceptional opportunities for clinical work, while the Royal and other asylums, the City Fever Hospitals, the Maternity Hospital, the Sick Children's Hospital, the Eye Infirmary, &c., give facilities for the study of special branches.

The degrees of B.Sc. and D.Sc. in Public Health and of B.Sc. in Pharmacy, are also now conferred. Of late the University has made considerable efforts to extend its laboratory accommodation and equipment, to augment its teaching staff, and to encourage post-graduate and research work. Within the last few years there have been provided new laboratories in the departments of pathology, anatomy (costing £13,000), chemistry, and surgery (costing £9,900); while new laboratories, to cost, with equipment, upwards of £60,000, are now approaching completion, for the departments of physiology, materia medica, and medical jurisprudence and public health.

Bursaries and prizes to the annual amount of about £1,000 are appropriated to medical students, including an Arthur bursary for women, £20 for three years.

Several bursaries open to students in any faculty are not infrequently held by medical students, and Scholarships and Fellowships to the annual amount of £1,600 may be held by medical students who have gone through the Arts course.

Queen Margaret College for Women. — Founded in 1883 (by the Glasgow Association for the Higher Education of Women, which was formed in 1877 with the object of bringing University instruction, or its equivalent, within the reach of women), Queen Margaret College in 1890 added to its faculty of Arts a School of Medicine for Women. This was organised entirely on University lines, and with the view of preparing for University degrees; and when, in 1892, in consequence of the Ordinance of the University Commissioners authorising the Scottish Universities to admit women to instruction and graduation, Queen Margaret College became the Women's Department of the University of Glasgow, its classes in medicine taken previously to its incorporation with the University were recognised as preparing for the degree. A full course of study for M.B. and Ch.B. is given by University professors and lecturers, with excellent facilities for hospital and dispensary work in the Royal Infirmary and other hospitals. A Hall of Residence for the students was founded in 1894. Fees for the classes at Queen Margaret College may be paid by the Carnegie Trustees; and several bursaries are open to women students of medicine,

The Winter Session begins on 17th October. The prospectus can be obtained from the hon. sec., Miss Galloway, Queen Margaret's College, Glasgow.

UNIVERSITY OF ABERDEEN.

The University of Aberdeen possesses under its charters the amplest privileges claimed or enjoyed by any academical institution. It confers degrees in the five faculties of Arts, Science, Divinity, Law, and Medicine. It also grants diplomas in Public Health, Agriculture, and in Education. It is, moreover, a teaching body equipped with twelve distinct chairs in the various branches of medicine and surgery. The majority of the professors devote their whole time to the work of the chairs. There are fully-equipped laboratories, the accommodation for which has recently undergone considerable extension. The degrees of M.B. and Ch.B. are conferred together; they cannot be obtained separately. The curriculum of study is nearly the same as in the University of Edinburgh; the regulations in the preceding columns will therefore apply here. Two years must be passed at Aberdeen. With regard to fees, each candidate for the degrees of M.B. and Ch.B. must pay a fee of £5 5s. in respect of each of the first three professional examinations, and £7 7s. for the final examination. Total cost, exclusive of the fees for degrees, is about £120. Besides the Royal Infirmary, students have the opportunity of attending several other local institutions where special courses of instruction are given. Perpetual fee for hospital practice is only £6. The professional examinations are held twice in each year, namely, in March and July, directly after the close of the winter and summer sessions.

Bursaries.—Bursaries, Scholarships, and Fellowships to the number of fifty, and of the annual value of over £1,180, may be held by students of medicine. (See "University Calendar.")

The Degree of M.D.—The degree of Doctor of Medicine may be conferred on any candidate who has obtained the degrees of M.B. and C.M. (Old Regulations), is of the age of twenty-four years, and has been engaged subsequently to his having received the degree of M.B. for two years in attendance in a hospital, or in military or naval medical service, or in medical or surgical practice, and has presented a thesis which has been approved of by the Medical Faculty. Candidates for the degree of M.D. (New Regulations) are required to pass an examination in clinical medicine in addition to presenting a thesis. Similar regulations apply to a degree of Ch.M. (Master of Surgery).

A Diploma in Public Health is conferred after examination on graduates in medicine in any University in the United Kingdom. Regulations may be seen in the "Calendar," or obtained on application to the Secretary the Medical Faculty.

Aberdeen Royal Infirmary.—This is a well-equipped institution, containing 250 beds, and affords excellent opportunities for clinical study to students at the Aberdeen University. The city, moreover, offers inducement in the way of cheaper living and comparative quiet to that obtained in Edinburgh and Glasgow, and will doubtless be preferred by some on this account.

ST. ANDREWS UNIVERSITY.

United College St. Andrews and University College, Dundee.

This University (session opens October 15th) grants the degrees of M.B., Ch.B., M.D., and Ch.M. The degrees of the University are open to either sex. For the degree of M.B., Ch.B., two of the five years of medical study must be spent in the University of St. Andrews; the remaining three may be spent in any University of the United Kingdom, or in any foreign, Indian, or Colonial University recognised for the purpose by the University Court, or in such medical schools or under such teachers as may be recognised for the purpose by the University Court. The preliminary examination and the professional examinations are of the same character as in the other Scottish Universities. A Diploma in Public Health is also granted by the University of St. Andrews to graduates in medicine of any University in the United Kingdom. Twelve months must elapse between the date of graduating in medicine and entering for the examinations for the diploma. The course of study required consists of (1) a six months' course of practical chemistry, bacteriology, and the pathology of diseases transmissible from animals to man in a laboratory of the University of St. Andrews; (2) six months' work with a medical officer of health; (3) three months' clinical instruction in infectious diseases. Subjects for first examination:—Chemistry, physics, bacteriology, and meteorology. Second examination:—Sanitation, sanitary law, vital statistics, medicine in relation to public health.

University College, Dundee, was affiliated and made to form part of the University of St. Andrews on January 15th, 1897, and the whole medical curriculum may be taken in the College. The United College, St. Andrews, offers classes for the first two years of professional study.

Bursaries and Scholarships.

United College, St. Andrews. — Malcolm bursary, £25 a year, tenable for five years. Fourteen Taylour Thomson bursaries, £30 to £20, five tenable for one year, nine for two, open to women only proceeding to graduate in medicine.

University College, Dundee: — Eleven entrance bursaries of £15, open to women for arts, science, or medicine, tenable for one year. Four £20 and three £15 second year bursaries for men or women in arts, science, or medicine, tenable for one year. Four £20 and two £15 third year bursaries for men or women in arts, science, or medicine, tenable for one year. Two Educational Trust bursaries of £25, tenable for three years. Applicants must have attended a public or State-aided school in Dundee for at least one year before examination. Bute bursary, annual income from £1,000 (men only).

Preliminary Examinations.—The dates of the next two examinations are September 27th, 1907, and March 27th, 1908. Schedules (obtainable from the Secretary of the University) to be returned filled up, and fees paid by September 14th, 1907, or March 11th, 1908.

Fees for Degrees.—Total fees for M.B., Ch.B., are the same as at other Scottish Universities, *i.e.*, 22 guineas (payable in instalments). Fee for the degree of M.D., and also for that of Ch.M., is 10 guineas in each case. For the Diploma of Public Health examinations the fee is £5 5s. for each of the two examinations.

Class Fees.—The fee payable in each of the following classes is 4 guineas, *viz.*:—Chemistry, physics, zoology, botany, physiology, anatomy, materia medica, pathology, forensic medicine, and public health, medicine, surgery, and midwifery. The fee for the practical classes in these subjects is 3 guineas each. In clinical surgery, clinical medicine, ophthalmology, diseases of the throat, nose, and ear and mental diseases, the class fees are 2 guineas each. The fee for Public Health chemistry required for the D.P.H., is 7 guineas. A special class in Bacteriology is also held for the D.P.H. for which the fee is 3 guineas.

Dundee District Asylum.—The appointments include a qualified resident assistant and two resident clinical clerks. Clinical instruction is given.

Further information will be found in the Calendar of the university published by Messrs. Blackwood and Sons, Edinburgh, or can be had of the Dean of the Medical Faculty, Professor C. R. Marshall. (See advertisement page).

Dundee Royal Infirmary.—The Infirmary contains 360 beds, with a special ward for the treatment of children. Three resident qualified assistants are appointed annually. Clinical clerks and dressers are attached to the physicians and surgeons, and students are appointed to assist in the post-mortem room. Out-patients are seen daily at 9 a.m. The instruction given at the Infirmary is recognised for purposes of graduation by the Scotch Universities, the University of London, the University of Cambridge, the Royal University of Ireland, and by the Royal Colleges of England and Scotland. Hospital Ticket for the Infirmary, £2 2s. each session, or £3 3s. a year. Further information on application to the Medical Superintendent.

THE COLLEGES.

The Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the faculty of Physicians and Surgeons of Glasgow have made arrangements by which, after a series of examinations, the student may obtain the diploma of the co-operating bodies, and can register three diplomas under the Medical Acts, *viz.*, Licentiate of the Royal College of Physicians of Edinburgh, Licentiate of the Royal College of Surgeons of Edinburgh, and Licentiate of the Faculty of Physicians and Surgeons of Glasgow.

The three bodies grant their *single* qualifications only to candidates who are already registered as possessing another and opposite qualification in medicine and surgery as the case may be.

Regulations of the Conjoint Board of the Royal College of Physicians of Edinburgh and the Royal College of Surgeons of Edinburgh and the Faculty of Physicians and Surgeons, Glasgow.—The candidate must produce certificates of having attended the following course of lectures, the certificate distinguishing the sessions and the schools in which the courses were attended. Anatomy, six months; practical anatomy, twelve months; chemistry, six months; practical chemistry, three months; materia medica, three months; physiology, six months; medicine, six months; clinical medicine, nine months; surgery, six months; clinical surgery, nine months; midwifery, three months; medical jurisprudence, three months; pathology, three months. The candidates must also produce the following certificates:—(*a*) Of having attended six cases of labour under the superintendence of a registered practitioner. (*b*) Of having attended for three months' instruction in practical pharmacy. The teacher must be a member of the Pharmaceutical Society of Great Britain, or the Superintendent of a laboratory of a public hospital or dispensary, or a registered practitioner, or a teacher to a class of practical pharmacy. (*c*) Of having attended for twenty-four months the medical and surgical practice of a hospital, containing eighty patients, and possessing distinct staffs of physicians and surgeons. (*d*) Of having attended for six months the practice of a public dispensary, or of having assisted for six months a registered practitioner. (*e*) Of having been instructed in vaccination.

First Examination, Fee £5.—The first examination shall embrace chemistry, physics, and elementary biology, and shall take place not sooner than the end of the first year, including a winter and summer session. Candidates who desire to enter for the first professional examination must produce certificates of attendance on chemistry, practical, chemistry, anatomy, and six months' practical anatomy.

Second Examination, Fee £5.—The Second examination embraces anatomy and physiology and shall not take place before the termination of the summer session of the second year of study. Candidates must produce certificates of attendance on anatomy, practical anatomy, and physiology.

Third Examination, Fee £5.—Comprises the subjects of pathology, materia medica, and pharmacology and advanced anatomy.

Final Examination, Fee £15.—The Final examination embraces medicine (including therapeutics and medical anatomy, clinical medicine); surgery (including surgical anatomy and surgical pathology); clinical surgery; midwifery and gynæcology, medical jurisprudence and hygiene; and shall not take place before the termination of the full period of study.

Subjects of Preliminary Education: (1) English grammar and composition; (2) Latin, grammar, translation from specific authors and easy unseen translation; (3) (*a*) arithmetic, to vulgar and decimal fractions; (*b*) algebra, to simple equations; (*c*) geometry, to the first two books of Euclid; (4) elementary mechanics of solids and fluids, comprising the elements of statics, dynamics, and hydrostatics; (5) one of the following:—(*a*) Greek; (*b*) French; (*c*) German; (*d*) Italian; (*e*) any other modern language; (*f*) logic; (*g*) botany; (*h*) zoology; (*i*) elementary chemistry.

Qualification in Public Health: The College of Physicians, in association with the Royal College of Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, confers a certificate of competency in public health. The examinations are held in April and October. Fee, £10 10s.

For the special regulations of the Royal College of Surgeons of Edinburgh, intending candidates should apply to Mr. James Robertson, 48, George Square, Edinburgh; and for those of the Royal College of Physicians, to Dr. H. Rainy, 16, Great Stuart Street, Edinburgh.

The Fellowship of the Royal College of Physicians of Edinburgh is conferred only by election, and the candidate must have been a member of the college for at least three years, and have attained the age of twenty-seven years.

The Membership is conferred only on a licentiate of a college of physicians or graduate in medicine of a British or Irish University, provided he shall have attained the age of twenty-four years and shall have passed an examination on: (1) medicine, including therapeutics (2) on one of the following optional subjects, *in which a high standard of proficiency is expected* —(*a*) a department of medicine specially professed; (*b*) psychological medicine; (*c*) pathology; (*d*) medical jurisprudence; (*e*) public health; (*f*) midwifery; (*g*) gynæcology. The examination is of a searching character extending over three days, the first of which is devoted to clinical and side room work, and written commentary on a case examined. The second day is taken up by written papers, and the third by practical examination on special subject and orals.

The fee for membership is 35 guineas, for fellowship 38 guineas, with a stamp duty of £25—£101 13s. in all.

The licence, or single qualification in medicine, is conferred on candidates who already possess a recognised qualification in surgery. The examinations for this licence are held on the first Wednesday of each month, save those of September and October, in medicine, materia medica, midwifery, and medical jurisprudence. The fee is £15 15s., and intending candidates should communicate with the Secretary of the College at least eight days before the date of examination.

The Fellowship of the Royal College of Surgeons of Edinburgh is conferred (except under certain conditions as to age and professional standing) only on candidates who have passed a special examination, and have previously obtained a diploma from the college, or from either of the Colleges of Surgeons of England or Ireland, or the Faculty of Physicians and Surgeons of Glasgow, or the surgical degrees of the Universities of Great Britain, and who are twenty-five years of age. The subjects for examination for those who are already Licentiates of the College are on the principles and practice of surgery, clinical and operative surgery, and one optional subject.

Those who are not Licentiates of this College: on principles and practice of surgery, clinical and operative surgery, surgical anatomy, and one optional subject; and in such supplementary subjects as have not, in an adequate manner, been included in the examination for the registrable surgical qualification possessed by such candidates, and which are required in the examination for Licentiates of this College.

The optional subjects shall embrace: (*a*) Surgery, special branches; (*b*) advanced anatomy and physiology; (*c*) surgical pathology and morbid anatomy; (*d*) midwifery and gynæcological medicine and surgery; (*e*) medical jurisprudence and hygiene; (*f*) practice of medicine and therapeutics. The examinations are written, oral, and practical. Three weeks' notice must be given to Mr. James Robertson, from whom full particulars as to certificates required may be obtained. The fee is £30 for those who hold the diploma of Licentiate of the College, and £45 to others (no stamp duty is payable on the diploma). Registered practitioners, aged not less than 40, who have been in practice for not less than ten years, and who have highly distinguished themselves by original investigations, may under special circumstances be elected without examination. Women are not admitted to the Fellowship of either college.

LICENCE.—The examination embraces the principles and practice of surgery (including operative surgery and surgical pathology), clinical surgery, and surgical anatomy, and shall not take place before the termination of the full period of study. Fee, £15 15s.

DENTAL DIPLOMA.—Every candidate for the dental diploma must have attended the general lectures and courses of instruction required at a University or an established medical or dental school recognised by the College as qualifying for the diploma in surgery. The fee is £10 10s.

Edinburgh Royal Infirmary.—Clinical instruction is afforded at this institution, which contains 800 beds under the supervision of professors of the University and the ordinary physicians and surgeons of the Infirmary. Special instruction is given on diseases of women, physical diagnosis, diseases of the skin, eye, ear, throat and teeth, and anæsthetics. Separate wards are devoted to venereal diseases, diseases of women, diseases of the eye, also to cases of incidental delirium or insanity, and three wards are specially set apart for clinical instruction to women students. Post-mortem examinations are conducted in the anatomical theatre by the pathologists. The perpetual fee, on one payment, £12; the annual fee, £6 6s.; half-yearly, £4 4s.; quarterly, £2 2s.; monthly, £1 1s. Separate tickets amounting to £12 12s. entitle the student to a perpetual ticket. No fees are payable for any surgical or medical appointment.

The appointments are as follow:—

1. Resident physicians and surgeons are appointed and live in the house free of charge. There is no salary. The appointment is for six months.
2. Non-resident physicians and surgeons (in the special subjects and for out-patient work) are appointed for six months. These appointments may be renewed.
3. Clerks and dressers are appointed by the surgeons and physicians. These are open to all students and junior physicians holding hospital tickets.
4. Assistants in the pathological department are appointed by the pathologists to conduct post-mortem examinations in the anatomical theatre.

ROYAL HOSPITAL FOR SICK CHILDREN.—During the year three courses of clinical instruction are given by the staff of the hospital, who are recognised as University Lecturers on the subject. The course consists of clinical lectures, ward cliniques, attendance at *post mortem* and out-patient cliniques. Hospital tickets, £1 1s.

SCHOOL OF MEDICINE OF THE ROYAL COLLEGES, EDINBURGH.

The government of this school, established in 1505, is now vested in a board which is equally representative of the two Royal Colleges and the Lecturers, the school being styled "The School of Medicine of the Royal Colleges, Edinburgh." The present number of lecturers is about sixty, of whom the greater number deliver qualifying courses of instruction of the same duration and scope as those delivered within the University, while a large number of non-qualifying courses on special subjects of interest to medical science, but which are not required for graduation, are delivered both in the winter and summer sessions. The students who attend the classes of the School of Medicine are largely students proceeding to the University degree, as well as those who are intending to take other qualifications, such as the triple qualification of the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow; that of the Royal College of Physicians of London, and the Royal College of Surgeons of England, and the degrees of the different Universities. The number of students attending the school averages 1,300 annually.

The minimum cost of the education in the School of Medicine for the triple qualification of physician and surgeon from the Royal Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, including the fees for the joint examinations, is about £120, which is payable by yearly instalments during the period of study.

The Winter Session opens October 2nd.

GLASGOW EXTRA-MURAL SCHOOL.

St. Mungo's College and Glasgow Royal Infirmary.—This college was incorporated in 1889 under its new title, being formerly known as the Glasgow Royal Infirmary School of Medicine. The Medical Faculty occupies buildings erected for the purpose of the medical school in the grounds of the hospital, and the laboratories, museums, and lecture rooms are of the most approved description. The college has been recently equipped with a complete electric light installation, and a powerful electric educational lantern. Attendance on the classes in St. Mungo's College qualifies for the medical degrees of the Universities and the medical and surgical colleges in accordance with their regulations.

The Royal Infirmary, which is at the service of the College for teaching purposes, is one of the largest general hospitals in the kingdom. It has over 600 beds available for clinical instruction, including an ophthalmic department, and it has special wards for diseases peculiar to women, for venereal diseases, burns, and diseases of the throat, nose, and ear. At the dispensary special advice and treatment are given in diseases of the eye, ear, teeth, and skin, in addition to the large and varied number of ordinary medical and surgical cases which in a great industrial centre daily require attention. Students at the college and hospital get the benefit of dispensary experience free of charge, and no better or wider field for seeing hospital practice and receiving clinical experience can be found than in the Glasgow Royal Infirmary.

Appointments.—All appointments are open. There are five physicians' and eight surgeons' assistants, who obtain free board and residence in the hospital and act in the capacity of house physicians and house surgeons. There is also a house surgeon for the ophthalmic department. These appointments are made for six months, and are open to gentlemen who have a legal qualification in medicine and surgery. Clerks and dressers are appointed by the visiting physicians and surgeons. From the large number of cases of acute diseases and accidents of varied character received, these appointments are valuable to students. In the pathological department assistants are also appointed by the pathologist.

Fees.—The fees for Lectures, including hospital attendance necessary for candidates for the Diplomas of the English, Scotch, and Irish Colleges of Physicians and Surgeons, amount to about £70.

Anderson's College Medical School, Glasgow.—New and excellently equipped buildings were opened in October, 1887, in Dumbarton Road, immediately to the west of the entrance to the Western Infirmary, and within four minutes' walk of the University. Extensive laboratory accommodation is provided for practical anatomy, practical chemistry, practical botany, practical zoology, practical physiology, practical pharmacy, operative surgery and public health. There are also provided a library, reading room, and students' recreation room. The buildings are constructed upon the most approved modern principles. The dissecting room is open in winter from 9 a.m. to 6 p.m., and in summer from 6 a.m. to 6 p.m. These students are assisted in their dissections by the professor and demonstrators, by whom daily examinations and demonstrations on the parts dissected are conducted. The supply of subjects is ample, and students are consequently provided with parts as soon as they may be ready for them. The dissecting room is provided with a complete series of dissecting specimens mounted in plaster of Paris illustrating the anatomy of the human body. There is also a large Bone Room, furnished with complete sets of painted and unpainted bones.

The various courses of instruction qualify for all the Licensing Boards in the United Kingdom, and for the Universities of London, Durham, Ireland, Edinburgh, and Glasgow, under certain conditions. The courses in public health (laboratory and lectures) are also recognised by the University of Cambridge.

The Carnegie Trust pays the fees of students at Anderson's College on conditions regarding which particulars may be obtained from W. S. McCormick, Esq., LL.D., Carnegie Trust Offices, Edinburgh.

Class Fees.—For each course of lectures (anatomy, ophthalmic medicine and surgery, aural surgery, diseases of throat and nose, and mental diseases excepted), first session, £2 2s.; second session (in Anderson's College), £1 1s.: afterwards free. For the following practical classes, *viz.*: Chemistry, botany, zoology, physiology, pharmacy, first session, £2 2s.; second session, £2 2s.; in botany and zoology, practical and systematic course together, £3 3s. Operative surgery, £2 12s. 6d.; second course, £2 2s. Joint fee for classes of systematic and operative surgery, £3 13s. 6d. Public health laboratory, £11 11s.; with lecture £12 12s. Ophthalmic, medicine and surgery, aural surgery, diseases of throat and nose, mental diseases—each, £1 1s.

Anatomy Class Fees.—Winter: First session (including practical anatomy), £4 4s.; second session (including practical anatomy), £4 4s.; third session, £2 2s. To those who have had the necessary courses of practical anatomy, the fee will be £1 1s. Summer: Lectures and practical anatomy, £2 12s. 6d; separately, £1 11s. 6d. each.

Royal Infirmary.—Fees: Hospital practice and clinical instruction, first year, £10 10s.; second year, £10 10s.; afterwards free. Six months, £6 6s.; three months, £4 4s.; pathology, both courses, £4 4s.; vaccination fee, £1 1s.

Dental Curriculum.—Students studying with a view to the dental diploma can obtain instruction in the following subjects: Physics, chemistry, anatomy, physiology, surgery, practice of medicine, and materia medica. The special dental courses may be obtained in the Dental School, 15, Dalhousie Street, Glasgow. Particulars may be had from D. M. Alexander, Esq., 97, West Regent Street.

The International Congress on the Protection of Infant Life will open in Brussels on September 12th, and will go on till the beginning of next week. It is the second international congress on the subject, the first having been held in Paris two years ago. It was instituted for the prevention of infant mortality, and the work of the congress falls under three headings, namely, those dealing with: (1) Giving advice to mothers; (2) Encouraging breast-feeding; and (3) The distribution of milk to those infants for whom breast-feeding is either impossible or insufficient. The Organising Committee of the Brussels Congress, however, consider the extension of this programme is necessary, and it is proposed to consider the question of widening the scope of the Congress so as to include all questions relating to the welfare of infants. The matter will be brought before the Congress this week, and there is little doubt that it will meet with a hearty welcome from the delegates.

There is a serious outbreak of small-pox in Vienna, and on Saturday 24,632 persons were vaccinated by public officials, making 106,000 in the last few days. The police have forbidden public meetings and processions.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 8th, 1907.

Obesity.

Obesity develops frequently after an acute infection, or in the course of a chronic infection. Such cases have been observed so constantly that Bouchard affirmed in his statistics that in one-fifth of the cases an acute affection might be found at the origin of obesity.

Experimentally, a notable increase in weight can be provoked by a toxic infection. It is thus that Professor Carnot obtained, in more than one instance, a considerable development by injecting cultures of the bacilli of Eberth into rabbits; their weight more than doubled.

Clinically, an embonpoint consecutive to an infection has been remarked long since, and one of the most frequently noted in this respect is typhoid fever; post-typhoid obesity is frequently observed during the convalescence; a remarkable reaction takes place in the tissues, glands, and the different systems; the appetite is, on the other hand, almost insatiable.

Obesity is observed also in the course of chronic suppurations and recently M. Carnot had seen a case where the obesity followed chronic renal suppuration.

Even in the course of cancer, where cachexia is the rule, the mesentery and the epiploon have been frequently found loaded with fat.

Among the cases of obesity due to infectious maladies, tuberculous and syphilitic obesity take the first rank.

The relations between obesity and tuberculosis are more frequent than is generally believed; stout tuberculous patients are not very rare.

It is thus that Laennec speaks of cases of tuberculosis where the patients maintained their embonpoint; and Milcent says that frequently a considerable local lesion coincides with an otherwise healthy condition, and even with embonpoint.

Ferrand and Quinquand remarked the facility with which certain scrofulous patients increased in weight under treatment.

Sarda and Vires speak of tuberculous patients in whom nothing reveals the pulmonary lesions with which they are affected. "It is certainly not on their face that the diagnosis can be read; they are generally more or less developed and some really stout."

Lemoine, in his lectures on fat phthisical patients, insisted on certain cases of torpid tuberculosis presenting externally all the appearance of health and even of embonpoint, and showed how such an aspect could lead to an error in prognosis.

These forms were, he said, frequently curable, the patients belonging more or less to the chlorotic type.

Daremberg, on the contrary, says that the embonpoint is deceptive; such patients prolong their life, it is true, but hardly ever get well; they are incapable of consuming an excess of food which poisons them if overfed.

M. Carnot has seen several cases of obesity provoked by the infection a few months after an attack of hæmoptysis; frequently, also, under the influence of overfeeding and rest, tuberculous patients have been known to increase more rapidly in weight than normal subjects.

It would similarly seem that in many agricultural shows, the fattest animals have been discovered to be affected with tuberculous ganglions.

Syphilitic obesity sometimes appears at the outset of the infection, and in a certain number of cases overfeeding has had some influence in predisposed subjects, but in the majority of cases the automatic regulation of nutrition does not act normally on account of the insufficient functions of the different glands of secretion genital glands, thyroid body, &c.)

Thus considered, and no matter how their intimate mechanism acts, obesity on the one hand, emaciation on the other, should be considered as morbid syndroma, indicating a trouble in nutrition, derived frequently from the same causes.

GERMANY.

Berlin, Sept. 8th, 1907.

At the Otological Society, Hr. Sonntag showed

Two Cases of Otitic Pyæmia.

A man, æt. 36, who had suffered from pain in the ear for a fortnight and a rigor twenty-four hours before. There were granulations and a fistula in the upper and posterior part of the wall of the auditory meatus. Temperature 41 C. The opened-up sinus looked velvety and pulsated. A fortnight later a secondary plastic operation was performed. Contrary to Voss, of Riga, he did not look upon puncture of the sinus as free from danger. He had seen the punctured spot become purulent. (*b*) A man, æt. 24, who had had suppuration of the left ear for a fortnight and two days ago a rigor with mental dulness and a yellow tinge of the skin. The meatus was swollen. No nystagmus. The part was completely chiselled out. Cholesteatoma. Fistula of the horizontal semi-circular canal. The sinus, when opened up, appeared to be collapsed. Opening of the sinus, which contained a little fluid. The sinus was bordered on both sides by solid thrombus. The temperature from that time remained normal, and a month later a plastic operation was performed.

Neuronal.

(*c*) Dr. George Dreyfuss, of the University Irrenanstalt, Heidelberg, reports his experiences with neuronal in the Therap. Monatsh. May, 1906. The drug was given to seventeen patients in 1905, sometimes as a calmative, when there was great excitement, and sometimes as a hypnotic, when all other means of overcoming the sleeplessness failed. The sleep produced lasted variously, according to the degree of excitement or agrypnia. Calm and only sleepless patients generally went to sleep in a quarter to half an hour after taking the medicine. The sleep was deep and mostly uninterrupted. Excited patients took a longer time, one to three hours or even longer before sleeping, but they frequently quieted down in an hour. The doses, according to the object aimed at, varied in amount; 0.5 gm. sufficed in simple cases of sleeplessness, but 1 gm. was required in obstinate cases. In cases of excitement, especially those of a catatonic kind, larger doses had always to be given; 1.5 gm. as a minimum, 2 gm. as an average, and sometimes as much as 2.5 gm. These doses were never exceeded in the twenty-four hours. There were disagreeable effects in two cases. In one, violent headache came on the second day; in another, an arterio-sclerotic patient, who had been given 2 gm. of the medicine, it had to be stopped as it caused headache, mental disturbance and a very marked rapid and dicrotic pulse. It did not appear to have any cumulative properties, nor was it observed to lose its effect. In many patients high doses were given for three or four weeks together, and the like effect was produced, whether given in the form of powder or tablet. In certain control experiments veronal alone appeared in general to be superior to neuronal. Chloral was not so certain, whilst trional was less powerful and the like effect was only obtained by larger doses (neuronal, 1 to 1.5 gm.; trional, 2 gm.). Paraldehyde failed completely even in large doses, in one case in which neuronal was quite successful.

AUSTRIA.

Vienna, Sept. 8th, 1907.

Pleiochromic Icterus.

Soucek in a long article on the origin of urobilin relates several cases of pleiochromic icterus, which he recognises as a transformation of the bilirubin into urobilin. This is an old controversy. Whence comes the urobilin? In this case Soucek is in favour of the transformation theory from biliverdin and bilirubin, and it may or may not be a normal constituent of the urine. Urobilin has the chemical formula of hæmatoidin, but differs in spectroscopical analysis. Others have it that urobilin is only a hydroxid of bilirubin and can be obtained from the latter by deoxidation, according to Jaffe's experiments. MacMun, on the other hand, affirms that there is no identity existing between urobilin and hydrobilirubin, and further assures us that there are two urobilins to be found in the urine, while some authors aver that frequently no urobilin can be found in perfectly healthy urine. Here we have a wide divergence of opinion all based on experiments. MacMun has a febrile urobilin and a normal urobilin, both bodies having a similar chemical composition, but differing in their spectroscopical analysis; in normal urobilin the absorption line disappears, while in the febrile does it not. The æther solution of the febrile has two faint lines near D, while the normal has nothing. From this he reasons that the product is an aqueous peroxide of a sulphuric alcoholic hæmatin solution, which is identical with normal urobilin. Other experiments have got yellow, red and brown lines on both sides of D, which weaken the last theory. Stokvis affirms that the urobilin is obtained from the bilirubin. Hoppe-Seyler has it from the hæmaglobin and hæmatin, while Nobel believes it is a form of hæmatoporphyrin

Whatever the body may be Soucek found an entire absence of bilirubin throughout a febrile illness, while the urobilin reaction was constantly present. The blood was analysed at the same time and found to contain bilirubin. This, he thinks, settles the question that urobilin is nothing more than a transformation of bilirubin which takes place in the kidneys.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

Public Health.—The report of the Medical Officer of Health at the last monthly meeting of the Corporation showed the lowest death-rate that has been known in the city for many years, 15.4. That from zymotic diseases was 1.0, and from chest affections, 5.2. During the preceding four weeks the cases of cerebro-spinal meningitis which had been notified, numbered 13, so that a steady decline in the epidemic goes on. Erysipelas, which had been rather prevalent lately, was also declining One case of anthrax occurred. There are now only seven cases of cerebro-spinal meningitis under treatment at the Purdysburn Fever Hospital. It appears that the public has got over its dread of the disease, which was at first fostered by the alarmist paragraphs in the daily Press, and as case to case infection is, to say the least, not very obvious, cases are now kept at home instead of being sent to hospital.

Queen's College: President's Annual Report.—President Hamilton's annual report, just issued, shows the College to be in a most flourishing and satisfactory state. The number of students is high in all faculties, and the facilities for study, thanks to the Better Equipment Fund, are greater than they ever were. Seven assistants have been appointed in various departments, including Dr. Howard Stevenson, as assistant to the professor of surgery, and Dr. C. G. Lowry to the professor of midwifery. Six of the seven new appointments are filled by old students of the College, and the President points out that these appointments confer a double benefit, helping brilliant young graduates of the school, and encouraging research and higher education. Twenty years ago the entire teaching staff of the College numbered just twenty, and now that number is doubled. The new laboratories, which are to be opened by Lord Kelvin at the end of this month, will also add to the teaching facilities of the College. These have been provided out of a Treasury grant of £5,400, with an equal sum contributed by the Better Equipment Fund, and bring the number of laboratories in the College up to eight, all well fitted and convenient for work. A new scholarship, established by the munificence of Mr. Robert Mackay Wilson, Fitzwilliam Square, Dublin, will be much appreciated by medical students, as it takes the form of a travelling medical scholarship of the value of £100 per annum.

LETTERS TO THE EDITOR.

THE MEDICAL ASPECT OF DENTAL CARIES IN CHILDHOOD.

To the Editor of The Medical Press and Circular.

Sir,—I imagine that most physicians have long been familiar with the fact mentioned by your correspondent in The Medical Press and Circular of August 28th, that enamel when its development is complete is incapable of physiological activity. He makes an assertion, however, which I venture to question, when he says that the temporary teeth "can be influenced only through the mother." As a matter of clinical experience I make bold to say that there is no proof that this is so, on the contrary, there is much to suggest that the development of the enamel of the temporary teeth can be influenced very distinctly by disease after birth; and if it were necessary to quote a dental authority to show that this is possible, I would refer your correspondent to Tomes, who says in his "System of Dental Surgery," 4th edition, p. 98, "The calcification of the temporary teeth is not so far advanced at the time of birth but that we might expect them to be influenced by the occurrence of disturbing causes during the first month or two after birth"; and on p. 3, "The temporary teeth in a nine months' fœtus are partly formed. The central incisors are calcified through most of the length of the crown, but the lateral teeth are less advanced. The terminal points only of the canines are calcified while the masticating surfaces of the first temporary molars are completed except the enamel, which at this stage has not attained to more than half its thickness, a condition which is common also to the more anterior teeth."

Your correspondent seems even to doubt this possibility of influencing the development of the enamel of the permanent teeth after birth. It hardly seems necessary to quote dental authorities to show that for some years after birth the development of the enamel of the permanent teeth remains uncompleted, and is, therefore, capable of being influenced by disease and safeguarded by treatment which arrests the disease. It must be remembered that the mere fact that there is an outer surface of enamel does not show that the development of enamel is complete; the point which I wish to insist upon is that the thickness of enamel, upon which largely depends its effectiveness as a barrier to decay, can be influenced by nutritional disease in infancy and, although I did not say so in the remarks to which your correspondent refers, I think it is quite possible and likely that this applies in some degree to the temporary as well as to the permanent teeth. In conclusion let me say that none can be more conscious than I am that an adequate knowledge of dental pathology can only be obtained by special study and special experience such as a physician can hardly hope to attain; and if it seems presumptuous in a physician to criticise the remarks of a dental expert, I do so only in the hope that clinical medicine may gain fuller knowledge from the excellent scientific investigations which so many dental surgeons are making nowadays on obscure points such as the influence of disease in early life upon the development of the teeth.

I am, Sir, yours truly,

Geo. F. Still.

114 Harley Street, W., Sept., 2nd, 1907.

THE INEBRIATES' ACT.

To the Editor of The Medical Press and Circular.

Sir,—All those who are working to combat the evils which the Inebriates' Act was designed to deal with will be glad to hear of the announcement made by Canon Horsley in the *Times* of September 2nd. The Council of the Church of England Temperance Society is asking for a departmental enquiry into the working of the Act, and the value of the various "cures" for the reclamation of alcoholics and "narcomaniacs," and the Home Secretary has promised to receive a deputation on this subject early in the autumn. A departmental enquiry could easily be made to expose the true character of the numerous bogus and fraudulent drink cures now so extensively advertised. Some of these impostures are under the patronage of parsons and soft-headed philanthropists who ought to know better. Canon Horsley could, no doubt, easily put his finger upon some of the former class. An elementary knowledge of the psychology and pathology of the inebriate which any educated man can acquire, is sufficient to guard one against acceptance of the claims which the bogus drink-cures put forth; and the educated men who support these cures can be only such as are, in spite of their general culture, ignorant of science or perhaps scorners of science and of scientific methods. Inebriety is not always due to one and the same cause. On the contrary its causation is always extremely complex, being made up of many widely varying physical, mental, and moral factors. To claim for any drug or combination of drugs the power to attack and destroy these factors, is to claim to work miracles; and when the procedures and remedies of the miracle-monger are kept secret, and worked for commercial considerations, no sensible man of the world, and least of all a medical man of the world, will have anything whatever to do with them. A discoverer of a cure for drunkenness by drugs or any other simple means would rank among the greatest benefactors of mankind, with Jenner, Pasteur, and Lister. Wealth would surely be his, and honour—a monument in every civilised land. It is not conceivable that any real man of science would for gain withhold such a boon from suffering humanity, or would hesitate to place his discovery with full disclosure of its nature in the hands of men of science who alone are competent to tests its merits. The bogus drink-cure proprietor forms in truth one class of the army of medical impostors whose methods call for investigation by a Royal Commission as advocated so persistently in the Medical Press. If the trade of these men did no more than plunder the simple and suffering it would be bad enough; but the trade is mostly pursued with cynical and callous disregard of the injury to health and the misery it inflicts upon its victims. It is impossible to believe that if the story were once publicly told and established by evidence laws would not be speedily devised to put an end to this nefarious traffic.

I am, Sir, yours truly,

Sept, 2nd, 1907. H. S.

THE ANNUAL CATHEDRAL SERVICE OF THE GUILD OF ST. LUKE.

To the Editor of The Medical Press and Circular.

Sir,—May I draw attention to the advertisement appearing in the present issue of The Medical Press and Circular respecting the Annual Festival Service of the Guild of St. Luke, to be held at St. Paul's Cathedral on October 22nd, and request that those who desire to attend will communicate with me as soon as possible. As we are expecting a large attendance from the City Companies and others, we are anxious to allot space as soon as possible.

Claude St. Aubyn-Farrer,
Registrar.

Westbourne Park Road,
London, W., Sept. 7th, 1907.

Dr. W. H. Allchin, consulting physician to Westminster Hospital, will deliver an introductory address on the present state of medical education in London at the opening of the Medical School on October 1st. On October 4th Sir Samuel Wilks will occupy the chair at the first meeting of the Guy's Hospital Physical Society, when Dr. G. A. Gibson is to read a paper, entitled "Past and Present."

NOTICES TO CORRESPONDENTS, &c.

☛ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial,* and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

ADVERTISEMENTS.

For One Insertion:—Whole Page, £5; Half Page, £2 10s.; Quarter Page, £1 5s.; One-eighth, 12s. 6d.

The following reductions are made for a series:—Whole Page, 13 insertions, at £3 10s.; 26 at £3 3s.; 52 insertions at £3, and pro rata for smaller spaces.

Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

C. W.—The extracts you are good enough to send are not the sort of thing we care for in this journal. They may seem amusing to a certain class of reader, and we should recommend you to try our contemporary the *Winning Post.*

CLINICAL LECTURES.

The following lectures have been received, and are hereby acknowledged. They will appear in our columns week by week in the ordinary course:—

Corner, Edwd. M., B.Sc.Lond., M.B.Cantab, F.R.C.S., "Deformities of the Foot Associated with Abduction."

Heilbronner, M.D., Professor of Medicine in the University of Utrecht, on "The Early Diagnosis and Treatment of Progressive Paralysis."

Lepine, R. M., Professor of Medicine in the University of Lyons, on "Uræmic Meningitis."

Morrison, James, M.D.Lond., "Lingering Labour: its Causes and Treatment."

Nicholson, H. Oliphant, M.D., F.R.C.P., "The Prevention of Fever in the Puerperium."

Saundby, Robert, M.D., LL.D. (Hon.), F.R.C.P.Lond., "The Sphygnomanometer in Medicine."

Sinclair, Thomas, M.D., F.R.C.S., "Traumatic Epilepsy Treated by Operation."

Stephenson, Sydney, M.B., F.R.C.S., "Congenital Anomalies of the Eye."

Stoney, R. Atkinson, M.B., B.Ch., F.R.C.S., "Cancer of the Rectum" (illustrated).

Swan, R. L., F.R.C.S., "Tubercular Diseases of the Knee-Joint and the Treatment of Sinoval Cavities."

Yearsley, Macleod, F.R.C.S., "Osteosclerosis."

Optic.—We must say that in our opinion it is hardly consistent with what is due to your colleagues, to say nothing of encouraging unqualified practice, to continue to send prescriptions for spectacles to opticians who prescribe themselves. Opticians have shown themselves extremely obstinate and we believe foolish in asserting their independence in this matter, and while medical men can get but cold comfort out of the law, they can easily and safely combine, and send their patients for spectacles only to such ethically-practising spectacle-makers as they can rely on. If the shoemaker sticks to his last, he is all the more likely to make better shoes.

NOTICE TO HOSPITALS AND COLLEGE DEANS.

The Editor desires to thank those gentlemen attached to the various Schools and Hospitals for supplying him with the information from which the foregoing pages have been composed.

NOTICE TO OUR READERS.

As this number is mainly devoted to information necessary for students intending to join one or other of the various medical colleges, and for those who, having passed their curriculum, are about to enter the ranks of the profession, much of the ordinary matter which usually fills our columns is necessarily deferred till next week.

GRATUITOUS COPIES.

A very large number of copies of this issue are being sent gratuitously to all the educational establishments, hospitals, reading-rooms, clubs, and large hotels, in the United Kingdom, and to a large number in America, India, the Colonies, and on the Continent; should any of our readers desire to present a copy to a patient or friend who contemplates sending his son to a medical school, our publisher will be happy to supply him with a duplicate free of cost on receipt of address.

Dr. L.—The treatment of multiple warts of the fingers is as varied as most treatments for simple ailments. Have you tried lime water? The patient to drink a wineglassful of lime water with each meal. At any rate it can do no harm, and we should be interested to hear if you get any good results.

R. D. M.—Radium is still being used medicinally, and the demand for its use as a therapeutic agent has led the management of the Imperial Uranium Works, in St. Joachimsthal, Bohemia, to construct a special laboratory for the industrial production of radium compounds. The uranium ores of this locality contain higher percentages of the element than any other known deposits. The ores and the residues from the uranium extraction have hitherto been treated chiefly at Paris, where the method for isolating the minute traces of radium was perfected by Madame Curie and her husband. There will be manifest advantages in carrying out the extraction at the place of origin, in view of the enormous amounts of rock required for the production of a tiny fragment of a radium salt. Interesting likewise is the fact that an extensive sanatorium is being erected in the same locality, where patients can take baths in the water pumped from the uranium mines. This water seems to be sufficiently charged with radium compounds in solution to exert a distinct therapeutic action, and physicians have already begun to prescribe its use.

Old L. S. A.—The subject of Acroparæsthesia was dealt with at length in the Medical Press and Circular of April 10th, 1907, in a clinical lecture by Dr. A. T. Whiting. If you refer to that number you will find all the points on which you require information discussed.

Devonian.—Webbed fingers are always congenital, and in a simple case can be easily dealt with, *i.e.*, when the phalanges are not united. Simple incision of the web is often followed by reunion of the web, but a careful plastic operation, under an anæsthetic, the divided parts being sutured, will generally be successful.

Vacancies.

Durham University College of Medicine.—Demonstrator of Physiology. Salary, £200 per annum. Applications to Professor Howden, Durham College of Medicine, Newcastle-upon-Tyne. (See advt.)

Cambridgeshire, etc., Asylum.—Second Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors.

Torbay Hospital, Torquay.—House Surgeon. Salary, £100 per annum, with residence, board, and washing. Applications to H. J. Packe, Secretary.

London Temperance Hospital, Hampstead Road, N.W.—Resident Medical Officer. Salary, £120 per annum, board, lodging, and washing. Applications to A. W. Bodger, Secretary.

Gravesend Hospital.—House Surgeon. Salary, £100 per annum, with board and residence. Applications to A. E. Thomas, Secretary.

West Herts Infirmary, Hemel Hempstead, Herts.—House Surgeon. Salary, £100 per annum, with rooms, board, and washing found. Applications to the Rev. W. T. T. Drake, Boro' Gate, St. Albans.

Newcastle-upon-Tyne City Hospital for Infectious Diseases.—Resident Medical Assistant. Salary, £104 per annum, with board, lodging, etc. Applications to the Medical Officer of Health, Health Department, Town Hall, Newcastle-upon-Tyne.

Appointments

Dewar, J., M.B., B.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the St. Margaret's Hope District of the county of Orkney.

Flitcroft, T. E., L.R.C.P.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the North Bolton District of the county of Lancaster.

Glassington, Charles W., M.R.C.S.Eng., L.D.S., Dental Surgeon to the Duke of York's Royal Military School, Chelsea.

Gunn, A. B. M., M.B., M.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Westray District of the county of Orkney.

Lawry, Richard Coger, L.R.C.P.Lond., M.R.C.S.Eng., Medical Officer to the No. 1 District and Workhouse, Penzance.

Lawson, Thomas Cornelius, M.R.C.S.Eng., L.S.A., District Medical Officer by the Stratton Union, Cornwall.

Scott, Frederick R., M.B., B.S.Durh., Medical Officer of Tynemouth Workhouse.

Smith, G. McCall, M.B., B.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Strathmiglo District of the county of Fife.

Births.

Carr.—On Sept. 3rd., at Mowmacre, Chesterton, Cambridge, to Dr. and Mrs. Frank Carr, a son.

Corfield.—On Sept. 4th, at Field View, Upper Tooting, the wife of Edward Carruthers Corfield, M.R.C.S.Eng., L.R.C.P. and L.S.A.Lond., of a son.

Drew.—On Sept. 3rd, the wife of Douglas Drew, B.S., F.R.C.S., of a daughter.

Furnivale.—On Sept. 6th, the wife of Captain C. H. Furnivale, R.A.M.C., of a son.

Marriages.

Bruce—Bowden.—On Sept. 3rd, at St. John's Church, Dumfries, Lewis Campbell Bruce, M.D., F.R.C.P.E., second son of Major-General A. A. Bruce, retired Bengal Staff Corps, to Caroline Desborough, elder daughter of the late Major H. G. Bowden, of the 22nd Foot.

Daniel—Bapty.—On Sept. 6th, at Epsom Parish Church, Alfred Wilson Daniel, M.D., son of the late Dr. W. C. Daniel, of The Silver Birches, Epsom, to Lena Gertrude Lucie Lee Bapty, daughter of Samuel Lee Bapty, of Birmingham.

Deaths.

Chaplin.—On Sept. 3rd, at St. Leonards-on-Sea, Sophia Caroline, widow of the late Thomas Chaplin, M.D., of Jerusalem.

Clark.—On Sept. 4th, at Rose Hill, Dorking, Charles Mackinnon Clark, M.D., L.R.C.P., M.R.C.S., aged forty-two.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, SEPT. 18, 1907. No. 12

NOTES AND COMMENTS.

Board of Education and its Medical Staff.

THE Board of Education have certainly got to work, with a celerity unprecedented in the annals of Government departments, in their preparations for administering the Education (Administrative Provisions) Act. Indeed, there can be no doubt that they had their plans and arrangements well in hand before the Bill passed. In selecting Dr. George Newman for the post of Chief Medical Adviser to the Board, Mr. McKenna has made a wise selection. His field of choice was extremely wide, but we fancy it will be generally agreed that Dr. Newman's attainments, experience, and industry in public health and bacteriological work combine to fit him admirably for his new duties. Dr. Eicholz, who has been in the office for many years, will, of course, form one of Dr. Newman's staff, and the Board, it is understood, are anxious to get to work as quickly as possible with what material they have. In advising local authorities how best to proceed with the new task, which it is hoped they will all undertake in earnest, it is exceedingly important, if the medical inspection of school-children is not to disappoint lay administrators, that the more practical side of the work should be brought forward at first, leaving the more academic phases for subsequent consideration. It is difficult to raise popular enthusiasm over minute anthropometric measurements, whereas most people can appreciate the value of ridding children of adenoids or providing them with glasses. To such more tangible aspects of the problem it would be better to pay attention at first.

Deceased Wife's Sister.

IF the old saying *de minimis non curat lex* embalms a salutary principle of law, a still more obvious if less salutary one which shows itself at times, is that people care a great deal more for little laws than they do for great ones. Out of the mass of important legislation passed last session the only Act which has touched the public imagination or fired the pens of the autumn correspondents of the newspapers is the Deceased Wife's Sister Act. Now the question dealt with in that measure is trifling in the extreme. To begin with, women being longer-lived than men, the number of widowers comparatively speaking is small, and of those the number who re-marry is even less, and out of the remainder the ones who were so happy with their first wife as to wish to embrace another of the same family might be counted as single spies rather than in battalions. As the whole number of such in the country must have been waiting some time to have their marriages legalised, and as up to date only two couples have given notice of their intention to avail themselves of the privilege it really is a case of *de minimis*. However, an ecclesiastical point being touched, the whole country is divided into two camps waging religious war with all the fervour of Turks and Crusaders, and any stick being good enough to beat an infidel with, the anti-aunt champions have not failed even to invoke the physiological argument. This seems to run as follows: That on the *una caro* principle, if a man marries his sister-in-law and has children they will be liable to all sorts of degenerations and abnormalities.

Her Physiological Immunity.

IF the argument is to be pleaded seriously, we should demand some sort of evidential basis, but, needless to say, none is forthcoming. As in all "anti" campaigns, assertion and asseveration are more important that fact. Now presumably the greatest blessing about the Deceased Wife's Sister Act is that it will save an amount of valuable time every session, and that it has transferred the cock-pit of the dispute from the floor of the House to the lean columns of the autumn Press. But as to physiological argument, the "one flesh" principle will not hold water for a moment, whatever religious or even moral support it may have. Most practitioners have seen the children of first cousins presenting some of the minor if not the major stigmata of degeneration, and these no doubt are the result of consanguinity, although marriage in that degree has always been allowed by both Church and State. The prohibition of cousin-marriages is a matter which, if it came to the point, would derive an appreciable amount of physiological support. The suggestion, however, that a husband and wife in course of time acquire some of each other's characteristics, and that a husband, by marrying a sister-in-law, can reproduce those characteristics with added force in the offspring, is the most fantastic nonsense that good people in want of an argument ever strained out of books they do not understand. Medical men, as such, having no interest in the question but a physiological one, can nevertheless, assure the disputants that they had better confine their polemics within the bounds of Statute and Canon law, and leave alone the science of heredity against which there is such a multitude of real offences in civilised society that there is no need to import fanciful ones.

Dentistry a la "Daily Mail."

Strange things happen in the calling of medicine, but if the *Daily Mail* is to be believed, still stranger ones happen in the practice of dentistry. It is asserted by the New York correspondent of that journal that one George Davis, aged thirty-eight, who died recently in the County Hospital of Chicago, was diagnosed to have suffered from a broken neck. The symptoms complained of during life were pain in the neck and paralysis of the right arm, and they apparently came on after a visit to the dentist's. Davis had called on that practitioner with a view to having a painful tooth removed, and the molar being firmly set, the dentist had used a series of jerks to loosen it. The physicians who saw the patient subsequently believed that the neck had been dislocated by this treatment, and death occurred in due course. The account adds: "The name of the dentist is not known," and one is quite prepared to believe this modern Hercules will remain incognito. Indeed, it would be a pity if he did not, for he would be sure to dispute the impeachment, and if he was believed, the beautiful story with its pregnant suggestiveness would be spoiled. Let us take the innominate dentist on trust, and add this catastrophe to the list of surgical dangers attending minor operations, for its like we shall never look on again. What greater lesson could we have of the pitfalls that attend apparently simple operations or of the frailty of cervical vertebræ?

Hygienic Sheets.

There are so many hidden dangers to health in this world we have the misfortune to live in, that it is really questionable if some penal restriction should not be applied to scaremongers. These gentlemen go about trying to find some new horror wherewith to make our flesh creep, and the amount of ingenuity they expend in the pursuit of their avocation is astonishing. The last, and we imagine the silliest, of these menaces to health has been discovered by one Mr. Shuttleworth-Brown, inventor of the new hygienic bed-sheet. We all know Mark Twain's calculation showing the tremendous risk run by people who sleep in beds, but, apparently, the hygienic sheet would reduce this danger to the comparative security enjoyed by people who travel in submarines or dirigible balloons. The real danger of sleeping in bed consists in the erroneous notion possessed by servants that sheets should be turned. Of course, nothing of the sort should be done. If the sheet is turned, the particles of epithelium and so on that are rubbed off the skin get into the bedding, whereas if the sheet is never turned the epthelium remains where it was. Consequently, Mr. Shuttleworth-Brown has presented to the, world his new sheets, which have a tuck in them so that people may tell whether they have been turned or not. So that any servant who hereafter turns a sheet will have short shrift and no benefit of clergy. How the new hygienic sheet will catch on amongst those who prefer extravagant idiocy, we cannot say, but we should imagine that a sheet that would not wash would have an even better chance of popularity among them. The drivelling folly that is perpetrated under the name of hygiene is enough to make angels weep and all sensible people shudder at the very mention of the word.

Manifestations of Wisdom.

Wisdom is justified of her children, but since the inauguration of the era of manifestoes, many of the children of light seem to have lost touch with their notion of the eternal fitness of things. Or is it perhaps that they have only lost touch with their sense of humour? Drink having been manifestoed from two points of view, it is the turn of food. The week before last we published a strange and naïf document of a pro-vegetarian tint, and this week it is our privilege to give publicity to another ingenuous expression of opinion on a similar subject. The signatories of the latter draw attention to the interesting fact that "insufficient and improper food is a prominent factor in the causes to which degenerative tendencies might be ascribed." Surely these gentlemen might be a little bolder and omit the subjunctive. We fancy there would be found few to quarrel with them if they took their courage in both their hands and asserted point blank that insufficient and improper food does actually produce degenerative tendencies. Sam Weller, when he realised Mr. Pickwick's soft-heartedness, exclaimed in admiration that his master's heart had been born later than his body, and when we read this latest of manifestoes we begin to wonder if signatories' hearts are not similarly afflicted with an excess of juvenility. Is it really worth while to appeal to the "Lord Mayors and Mayors of London and of other cities and towns, all municipal authorities, and other good folk, to direct attention to this important subject?" In a word, might it not be taken for granted that if the people sin in eating insufficient and improper food, they probably do so not so much through ignorance as that either they have not enough money to buy sufficient food, or that they have too much money and so can afford improper food? At any rate, we would venture to throw out the suggestion for what it is worth.

LEADING ARTICLE.

A MEDICAL DEPARTMENT IN THE BOARD OF EDUCATION.

The gradual extension of the scientific method in the working of national administration is a process which, though at times slow and halting, may be regarded nevertheless as inevitable. So far as State education is concerned it is only within the last few years that the greatness and complexity of the health problems involved in that system have been recognised. At the present moment these questions are engaging the attention of "experts," medical, sociological, educational and political, in all the nations. Clearly, the subject is so far only partly explored, and investigators are faced with years of patient labour before facts can be properly ascertained, and the kaleidoscope of school life reduced to a plain presentation of cause and effect capable of statement in the form of a general law. In our own country it is reassuring to find that we are taking steps to bring ourselves up to the level of the sanitary standards enforced in the schools of other civilised nations. Of all the social measures passed by the Government during the Parliamentary Session that has recently come to a close, there is probably not one of greater and further-reaching importance than the Education (Administrative Provisions) Act, whereby provision is made for the compulsory medical inspection of children in elementary schools, and power is given to local authorities to make arrangements for medical treatment, as well as to establish what are known as play centres and vacation schools. It is now officially announced that the Board of Education have decided to establish a Medical Department for the purpose of giving them advice and assistance in the discharge of the new duties imposed by the above-mentioned Act. The chief duties of the Board in this direction will consist in advising and supervising local education authorities as to the manner and degree in which those authorities carry out this medical inspection; in giving such directions as may be necessary regarding the frequency and method of such inspection in particular areas, and in considering and sanctioning such arrangements as may be proposed under the Act by individual authorities for attending to the health and physical condition of the children. The Board will also collect and collate the records and reports made by the authorities in the process of carrying out the new duties imposed by the Act, and will issue an official annual report on the subject.

The national importance of this new departure it is hard to over-estimate. It provides in some sort a guarantee that in future the State will discharge the duty of safeguarding the health of the individual child. At length the voice of the reformer has carried conviction to the legislature, and in future the halt and the maimed, the crippled and the defectives of all kinds will be carefully tended from the first day of their entrance into the elementary schools. It follows infallibly that such a work carried out systematically and scientifically in the schools must go far in stemming the unnecessary waste of health and life that is steadily exhausting the vitality of the nation. It is obvious that a great task lies before such a Medical Department as that now added to the Board of Education. The special science it is called upon to administer is still in its infancy, and a suitable administrative machinery will have to be created. We understand that the precise details of the organisation and personnel of the new Department have not yet been determined. At the same time we are glad to hear, on good authority, that the work will be mainly that of a central controlling body, leaving wide powers of individual action to local authorities. Meanwhile, the President of the Board of Education has appointed Dr. George Newman, the well-known Medical Officer of Health of the Metropolitan Borough of Finsbury, to be Chief Medical Officer of the Board. He has an able lieutenant in the person of Dr. Alfred Eicholz, who has for nine years been on the Board's staff as Medical Inspector of Schools. It is further understood that the Board of Education will issue shortly to the local education authorities a circular setting forth their new duties in the matter of the medical inspection of school children. In conclusion we may reiterate our opinion that the creation of the new Medical Department marks one of the most important departures in public health that have been adopted by the British Government.

CURRENT TOPICS.

An Imperial Vaccinationist.

The news that an extensive smallpox epidemic has broken out at Vienna naturally raises some sort of wonder that in the twentieth century it is possible for such a thing to occur in a civilised country. It is a simple scientific proposition which asserts that any community protected by vaccination and re-vaccination has no need to fear the inroads of smallpox. Nor is it less self-evident that the terribly fatal infection of that malady runs riot when introduced into a population partially or wholly unprotected by vaccination. From these premises it follows that the Viennese, being seriously invaded by smallpox, must be inefficiently protected by vaccination. Precisely the same inference might have been made upon equally infallible grounds when London was ravaged by smallpox some years ago, when the disease picked out and decimated the unvaccinated population. Yet it is this vulnerable material that the anti-vaccinationist, in his blind fatuousness seeks to multiply, regardless of the deadly peril to which he is thereby exposing his countrymen. Were anti-vaccinationists to have their way the population of the United Kingdom would soon be reduced to the helpless state of a tribe of South Sea Islanders in face of an outbreak of smallpox. So far as orthodox medicine is concerned in Vienna, it has found a staunch supporter in the person of the Emperor Francis Joseph. At the advanced age of 77 years his Majesty was, naturally, at first somewhat loth to follow the advice of his medical advisers, but later allowed himself to be vaccinated. This act, simple in itself, is worthy of being recorded as characteristic of a king, who by a life of self-sacrifice and resolution, has raised his kingdom to a first rank among the nations of the world. Nor do we doubt that under similar circumstances our own countrymen would find themselves stimulated in no less a degree by kingly example.

An Echo of a Famous Manifesto.

Some months ago the wonder of the community was excited by an extraordinary manifesto in favour of alcohol, signed by a number of prominent medical men and published in the form of a letter by a prominent medical journal. That document was followed by a counter-manifesto from The Medical Press and Circular, signed also by various distinguished men in the profession, and stating that alcohol was unnecessary to mankind under ordinary conditions, while at the same time it had a restricted field of usefulness as a medicine. The points thus raised were taken up widely by the general Press, and have since been followed up with unremitting energy by the advocates of total abstinence. While there can be no question as to the absolute *bona fides* of those who signed the original manifesto, there is some reason to suspect that they have been made in some obscure way the catspaws for those interests on the commercial side of alcohol. At any rate, it has been often reported that their manifesto has been circulated by societies devoted to the brewing and distilling trades. The unwisdom of signing any public declaration of the kind is shown by the latest attack upon its character. Last week a lecturer in Birmingham is reported to have said that he had obtained the shareholders' lists of a number of companies and from a perusal of them he had discovered that three of the medical signatories of the original company held brewery shares. Although the gentleman in question, Mr. Tennyson Smith, made his statment to a public audience, we cannot but think he is labouring under a misconception of some kind. The incident, however, shows the extreme caution that should be exercised by any member of the medical profession who is invited to sign declarations of faith that may possibly be appropriated by unscrupulous persons for private ends.

Economical Poor-Law Dentistry.

THE boarding-out system applied to Poor Law children, excellent in itself, nevertheless requires constant supervision to prevent abuses. At Bristol, the homes in connection with boarded-out children have been reported upon by Dr. Fuller, the Local Goverment Board Inspector. The portion of his report dealing with dental matters deserves careful attention. He found that the teeth of many children were in a neglected condition, that carious teeth were left unheeded, that extractions were unnecessarily frequent, and that no provision was made for scaling the teeth. This state of affairs, the Inspector remarks, is hardly to be wondered at when the contract with the dentist is examined; for it can hardly be possible to ensure proper stopping at one shilling per tooth, especially when it is noted that the stopping is to be done with gold amalgam. In view of this report the Bristol Guardians have arranged for a routine examination of the children's teeth once every three months. The necessity of reporting adversely upon contracts of this nature could possibly be avoided were a more rigorous examination of the terms of such agreements carefully made by the Local Government Board in the first instance. Bristol has a good record as regards Poor-Law administration, and in this instance has shown a commendable desire to carry out its duties conscientiously.

Proposed Public Health Parliament.

THE activity shown nowadays in the various departments of public health science is no less conspicuous than it is unflagging. Hardly have we settled down after the recent Public Health and School Hygiene Congresses than we are faced with another excellent enterprise of a similar complexion. The proposal came in the first place from Dr. Armstrong, the well-known medical officer of health for Newcastle-upon-Tyne. His original idea was to summon a national congress to frame legislative suggestions for the consideration of Parliament with regard to the scourge of tuberculosis. From that nucleus the scheme has grown so as to include other urgent problems, for instance, infant mortality, milk, and meat supplies, the housing of the masses, the drink problem, the disposal of sewage, and so on. Dr. Armstrong suggests that delegates should be elected by constituted authorities on a basis of population, that they should meet in London as a representative Parliament, and frame measures for the guidance of the national Parliament at Westminster. The suggestion is altogether admirable and should the financial and other difficulties of organisation be satisfactorily surmounted, there is every prospect of its adding greatly to the establishment of public health as one of the chief factors in the world's progress.

The Emotional Theory of Infection.

LADY CARLISLE is an Englishwoman of whose kind-heartedness and fine philanthropy we may as a nation well be proud. Her attitude as regards infectious diseases, however, is one which, although inspired by motives of the highest and purest nature, are nevertheless, in our opinion, so prejudicial to the public interest that we venture to offer some sort of gentle remonstrance. Recently the Malton Rural District Council complained that infection was carried by poor children brought into their district by charitable agencies from Leeds and Bradford. Lady Carlisle has written to the *Leeds Mercury* a letter in which she practically declares her belief that there is no truth in the "infection scare." She draws a vivid picture of the joy of "the little ones as they ramble to and fro during the sunny summer days, gathering up stores of health and good spirits, and measuring in their quick little town brains visions of beauty," and so on. That is all very well, but the mere expression of Lady Carlisle's disbelief in infection does not lessen the virulence of the germs of diphtheria, measles, whooping-cough, tuberculosis, and so on, that are conveyed into "the cottage homes of this beautiful district" (Malton), by little infected town bodies. Surely the modern doctrine of the responsibility which forbids the individual to injure others by the spread of personal contagion justifies the attitude of the Malton Council. If poor children are to be imported thither from Leeds and Bradford, then it is imperative on those who send them to ascertain that they are free from infectious disease. The fatalism of the poor is a great obstacle in the way of preventing the spread of infectious diseases, but, happily, educated persons, as a rule, are alive to the scientific aspects of prevention.

Chicago in England.

THERE were many people who, at the time or the revelation of the Chicago horrors a year of two ago, had more than a suspicion that, if all were known, the conditions in many London factories were not such as to allow of our adopting a very superior air toward our American cousins. It is always much easier, however, to express indignation at atrocities far away than to search out injustices in the next street. A report recently issued by the Industrial Law Committee, though it does not make any sensational revelations such as came from Chicago, nevertheless shows plainly to what tyranny women and girls employed in the smaller factories of London are liable to be subjected. It is true that the Factory Acts have done much for their protection, but the great difficulty is to bring the law to bear on a particular injustice. Inspectors are not ubiquitous, and employers are often adept in evading the law. A girl who draws the attention of the inspector to a breach of the law is almost certain, directly or indirectly, to lose her employment. Several cases of this sort are quoted. Particulars, too, of a shocking nature are given as to the conditions under which many of these girls in the East End have to labour. In a box factory, seventy girls work in a varnishing room whose windows are never opened for fear of dust. In dressmakers' shops the hands may have to work from early morning till late in the afternoon in rooms unventilated and unheated, without, for seven or eight hours at a stretch, any break for meals. These are the kind of cases which the Industrial Law Committee investigate, and from their report it is evident that they are at no loss for material on which to exercise themselves.

Mr. Haffkine and India.

We are very glad to see from a leading article in *The Times* of September 7th that that journal definitely espouses the cause of Mr. Haffkine. In The Medical Press and Circular, among other journals, the injustice done to that eminent scientist has been the subject of strong protest, and we warmly welcome the strong influence of *The Times* on the same side. We agree with our contemporary that the Indian Government had a difficult decision to make and that they were bound to attach great weight to the advice of the experts, but now that it has been shown by the clearest evidence available that Mr. Haffkine was in no way responsible for the unhappy Mulkowal incident, the least that can be expected is that Mr. Haffkine shall be reinstated in his old post. It is less than justice to offer him, as Mr. Morley has told us the Government have done, an indefinite engagement carrying no specified status, for Mr. Haffkine might find himself in some invidious position from which he could not easily extricate himself if he accepted it. If a mistake has been made—and even the most official mind must admit that such has been the case—surely only complete reparation can repair the harm that has been done. We can hardly believe that the Government of India intend indefinitely to stiffen their backs, but if they do, other means must be employed to show that instructed public opinion in this country cannot be denied its right of seeing that justice is done in the public services.

PERSONAL.

The King has been pleased to give and grant unto Bryden Glendining, Esq., M.B., Physician in attendance on her Majesty the Queen of Spain, his Majesty's Royal licence and authority that he may accept and wear the Insignia of Caballero of the Order of Carlos III., conferred upon him by his Majesty the King of Spain, in recognition of valuable services rendered by him.

It is expected that the new buildings of the Royal Army Medical College in London, now nearly arrived at completion, will shortly be opened by H.M. The King.

Dr. J. T. Wilson was president of the Congress of the Sanitary Association held in Aberdeen, and delivered the opening address.

Mr. Alfred H. Tubby takes the chair at the dinner of the Westminster Hospital Medical School on October 3rd.

Dr. Alfred Eicholz has been appointed to the staff of the new medical department of the Board of Education.

Captain W. H. S. Nickerson, V.C., M.B., R.A.M.C., has been appointed Sanitary Officer of the Northern Command.

Sir Herbert M. Ellis, Director-General of the Medical Department of the Royal Navy, will preside at the St. George's Hospital dinner on October 1st.

Major Ronald Ross, F.R.S., Professor of Tropical Medicine at Liverpool University, will distribute the prizes at the opening of the Leeds Medical School on October 1st.

Sir Almroth Wright delivered the inaugural lecture of the post-graduate medical classes at the Royal Infirmary, Glasgow, his subject being "The Principles of Vaccine-Therapy."

Mr. J. C. McWalter, M.A., F.F.P. & S.Glas., M.D. Brux., D.P.H., Barrister-at-law, has been appointed Examiner in Medical Jurisprudence to the Apothecaries' Hall.

Dr. George Newman, F.R.S.E., D.P.H., Medical Officer of Health for Finsbury, has been appointed Chief Medical Officer to the Board of Education.

The long-service medal has been awarded to Surgeon-Major Ernest W. Barnes, of Liverpool; a well-earned recognition of his long and energetic connection with the volunteer force.

The Royal Commission on Mines have appointed Dr. A. E. Boycott, M.D., of the Lister Institute of Preventive Medicine and Guy's Hospital, to make an investigation with a view to determining whether there are any indications of the disease known as ankylostomiasis (miner's worm) in coal mines in Great Britain.

On October 4th, Sir Samuel Wilks will occupy the chair at the first meeting of the Guy's Hospital Physical Society, at the opening of the session, when Dr. G. A. Gibson is to read a paper, entitled "Past and Present."

It is notified in the *Gazette* that the King has nominated Mr. David Caldwell McVail, M.B., to be, for a further period of five years from October 28th, 1907, a member of the General Council of Medical Education and Registration of the United Kingdom, for Scotland.

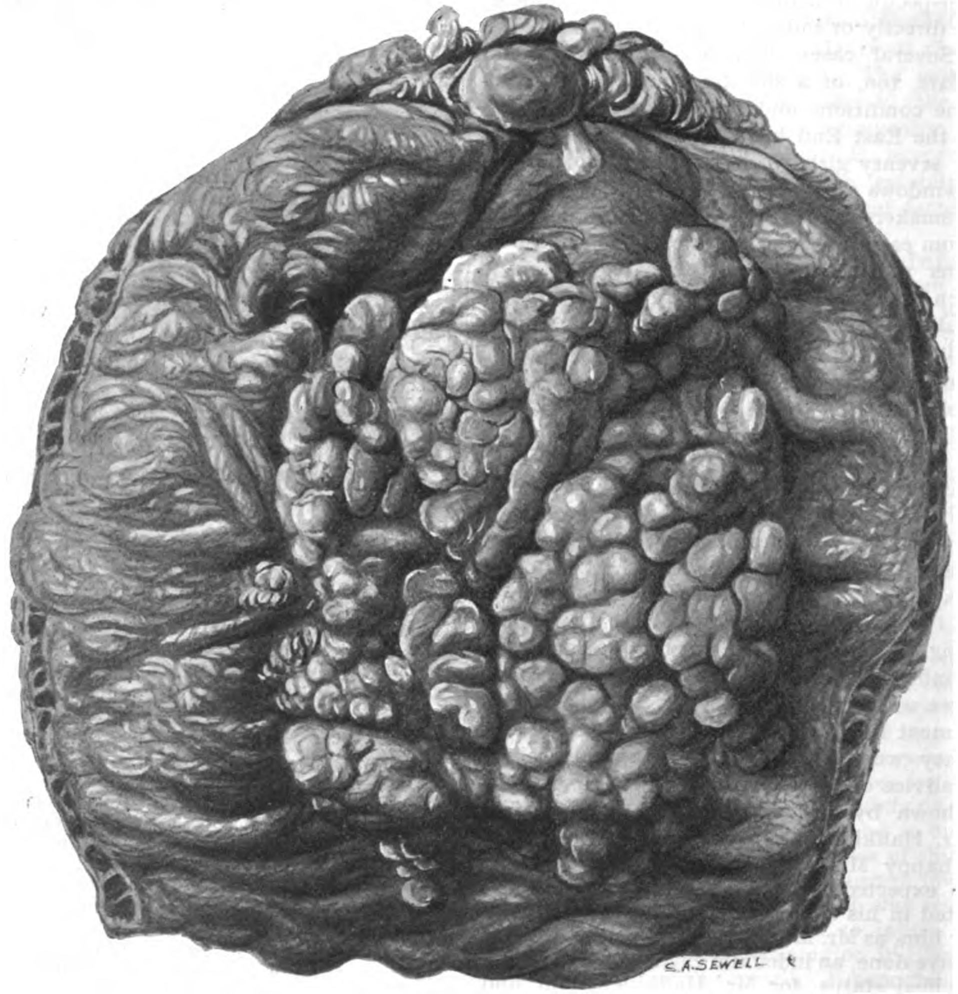
Mr. James Burdett Moxon, of Brigg, Lincolnshire, surgeon, one of the oldest medical practitioners in England, who died at the great age of 95, left estate of the gross value of £1,113 11s. 9d., of which £1,095 11s. 8d. is net personalty.

A Clinical Lecture
ON
CANCER OF THE RECTUM. (a)

By R. ATKINSON STONEY, M.B., B.Ch., F.R.C.S.,

Surgeon to the Royal City of Dublin Hospital; Lecturer on Surgery at the Royal Medical Services School, &c.

I HAVE chosen this subject for lecture this morning for two reasons: first, the rectum is one of the commonest positions in the body to be attacked by cancer; secondly, this is one of the forms of cancer which frequently remains unrecognised till late, and this in spite of the fact that probably at least ninety per cent. of these growths are palpable by the finger examining the rectum, even at an early stage. I hope before I have finished this morning to explain why this disease is so often overlooked for a long time, and to put you on your guard, so that you may make an early diagnosis in these cases.



Specimen (actual size) from Case III. The rectum with the anal end uppermost has been opened to show the large cauliflower-like growth on the posterior wall.

We have had three cases of rectal cancer in these wards within the last few months, and as they all show some points of special interest I shall commence by briefly recalling to your remembrance the main facts of these cases.

CASE I.—R. R., male, æt. 75, was admitted to this hospital on November 8th, 1905, suffering from a tumour of the rectum. He gave a history of pain in the back, increased by defæcation and difficulty in getting his bowels to move, with occasional traces of blood in his motions for some months. On rectal examination a large, irregular ulcer with thickened, hard, everted edges was felt on the posterior wall of the rectum, within about two inches of the anus. It was just possible to pass the finger to the upper limit of this ulcer. An operation was performed on November 25th, and the rectum with the growth was removed. It was found impossible to bring the upper end of the rectum to the anus, so a sacral anus was made, and the whole of the lower part of the bowel removed. The patient was discharged from the hospital a month later with the wound completely healed.

(a) Delivered at the Royal City of Dublin Hospital on Thursday, December 13th, 1906.

CASE II.—D. B., æt. 48, male, was admitted on March 18th, 1906, complaining of piles, alternating constipation and diarrhœa and pain in the region of the sacrum. On rectal examination a large mass was felt filling the upper part of the pelvis but no growth could be felt in the rectum. The following day the patient was examined under an anæsthetic with the electric sigmoidoscope; after it had been passed for about 6 inches without any growth coming into view, the patient coughed and the instrument appeared to move suddenly upwards, but no growth was visible; he was then returned to bed. Late that night the patient developed symptoms of commencing general peritonitis, and on opening the abdomen early the next morning diffuse peritonitis was found, evidently starting from a large foul-smelling pelvic abscess which had burst, probably during the examination on the previous morning; the adhesions in the pelvis were so numerous and complicated that it was difficult to make out where the abscess came from, but it was evidently in direct connection with the bowel, and there appeared to be a growth of the upper part of the rectum. The whole length of the colon was packed with scybalae, so a colostomy was performed and the abdomen washed out, and the pelvic abscess drained. The patient recovered from the peritonitis, but though he lingered for a month, the pelvic abscess continued discharging, and he died on April 20th. At the autopsy the whole pelvis was full of stinking pus, there was a large malignant growth of the upper part of the rectum, and a communication between the lumen of the bowel above the growth and the abscess cavity.

The third case you see before you, the patient, A. R., male, æt. 58, was sent up to the medical wards of this hospital from the country on October 3rd, 1906, supposed to be suffering from piles and some liver trouble. On examination after admission he was found to have a growth in his rectum, and was at once transferred to the surgical wards. On rectal examination a very large cauliflower-like growth was felt on the posterior wall of the rectum within three quarters of an inch of the anus, the finger could not reach its upper border, and the growth appeared fixed. On October 6th a colostomy was performed, and the rectum and pelvis examined at the same time. No enlarged glands could be felt, and the growth did not appear to have extended beyond the rectum. The intestine was opened on the 10th, and on the 27th the rectum was removed. The wound is now practically healed, and those of you who saw the patient on admission will notice the great improvement in his appearance, he has put on over a stone since the last operation, and is almost ready to return home. (*a*)

These three cases illustrate in a very beautiful manner the three types of cancer of the rectum proper which may occur.

(1) The ulcerous variety—this commences as a nodular growth or plaque involving part only of the circumference of the intestine. Sooner or later this breaks down and forms a typical, malignant ulcer with everted, thickened and hard edges, it usually grows slowly, and may not produce marked symptoms of obstruction. The first case was a very good example of this form.

(2) The cauliflower variety—this also starts as a nodular growth, but it extends fairly rapidly and finally forms a large, rough, irregular, cauliflower-like growth projecting into the lumen of the rectum, but it does not tend to ulcerate to any great extent; it may produce marked symptoms of obstruction. The third case was a very good example of this form, and here you see the actual specimen. (See illustration). Both of these two types usually grow from the posterior wall of the rectum.

(3) The annular variety tends early to involve the whole circumference of the gut, and as a rule ulcerates early, and by its contraction causes a well-marked constriction of the canal, giving rise to distinct obstructive symptoms, and sometimes leading to a perforation of the dilated bowel above. The second case more nearly approached this variety than either of the other two.

The symptoms of cancer of the rectum are often extremely vague, and are frequently put down to piles in the earlier stages. Pain is usually one of the first symptoms; at first it may be felt only during and after defæcation, or there may be merely a feeling of weight and dragging in the lower part of the back, and after defæcation the patient may feel that there is still something more to be passed. Later, when the growth ulcerates, there may be some blood with the motions; this is very rarely copious, but is, as a rule, only a streaking or staining of the motion with blood. When the tumour commences to cause obstruction, a very definite train of symptoms arises—there is tenesmus and straining and alternating constipation and diarrhœa. The latter is a spurious diarrhœa, and consists of fæcal-stained mucus; it is brought about as follows:—the growth causing obstruction leads to a retention of the fæces above the stricture, this leads to irritation of the mucous membrane with an outpouring of mucus, which collects and dissolves some of the hard fæces, and then this fæcal-stained mucus trickles through the stricture. Hæmorrhoids may be caused by the pressure of the tumour and the straining it leads to. In fact the onset of hæmorrhoids after the age of 40 or 50, with the passage of small quantities of blood, with alternating constipation and diarrhœa, may be looked upon as pathognomonic of cancer of the rectum, and should always lead to immediate digital examination of the rectum. This digital examination is the final test to which all suspected cases must be submitted, and as I mentioned before in a very large proportion of the cases the growth can be felt. It may also be seen by the proctoscope or sigmoidoscope. If the growth attacks the anterior wall of the rectum it may spread to the bladder and give rise to further symptoms, pain on micturition, discharge from the rectum whenever the bladder is emptied, or finally to a recto-vesical fistula. In the second

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(a) The patient returned to the country on January 3rd, 1907, with the wound completely healed, only a very small quantity of mucous coming daily from the lower end of the rectum which opens in the sacral region, and an artificial anus in the inguinal region over which he has some control.

case the patient met me one day in the street and said he must get something done, as he was suffering from piles. I advised him to come into hospital at once; but I did not see or hear of him again for over six months, when he told me the piles were worse, and on questioning him he told me he suffered from alternating attacks of constipation and diarrhœa, the latter being in the form of very frequent motions, when only a very small quantity was passed. This made me suspect cancer, and I insisted on his coming into hospital the next day for examination. In the third case the patient was treated in the country for several months for piles and liver trouble, the symptoms in reality being caused all the time by the growth in the rectum. These two cases should emphasise the fact that one must never be satisfied with making a diagnosis of hæmorrhoids in an elderly patient without a digital examination, or precious time may be lost.

Unfortunately, cancer of the rectum still gives very bad results after operation, and this in spite of the fact that the disease occurs in an organ which is easily removed completely, and that it tends to remain limited within the muscular coats of the rectum for a considerable period. These bad results can only be explained by the fact that most of the cases are operated on too late.

Considering now the question of what the surgeon can do for a case of cancer of the rectum, the ideal treatment is, of course, complete removal of the disease with restoration of the continuity of the alimentary canal and a preservation of the sphincteric apparatus of the rectum. For this to be possible the following points must be fulfilled :—removal of the growth must not involve removal of the anal canal, or at least the external sphincter must be preserved. After removal it must be possible to free the upper end of the bowel sufficiently to bring it, without tension, to the lower part. Frequently this ideal form of operation is not possible, and then one must be satisfied with a sacral anus, over which the patient has little or no voluntary control. This is more liable to occur in the case of males than females, as in the former the rectum is usually shorter and has not so long a mesentery.

The operations described for the removal of cancer of the rectum are generally divided into three types, according to the point from which the growth is attached :—(*a*) Perineal; (*b*) sacral; (*c*) and combined abdominal and sacral.

The perineal operation is rarely done, as it is only suitable to cases where the growth is situated very low down, involving really the margin of the anus or the anal canal.

The sacral is the form of operation applicable to the majority of cases. Here the rectum is attacked from behind, after removal of the coccyx and the lower one or two pieces of the sacrum. The removal of the sacrum must never extend above the level of the third sacral foramina, or the third sacral nerves will be cut, and as they supply both the rectum and the bladder, incontinence of both urine and fæces will result from their destruction. In some cases, especially where the growth is situated high up, it may be better to start the operation by an abdominal incision, through which the bowel is divided above the growth, the rectum freed and the superior hæmorrhoidal vessels tied, and the operation may be completed by an incision in the sacral region.

The advisability of performing a preliminary colostomy in the left inguinal region is a disputed question. The following are its disadvantages :—(*a*) it necessitates two operations instead of one; (*b*) it is difficult or troublesome to close this artificial anus if at the second operation it is found possible to unite the two ends of the rectum and preserve the normal anus; (*c*) it may prevent the upper end of the rectum being sufficiently freed to bring it down to the lower end; (*d*) there is a more or less sentimental objection to the presence of an artificial anus in the inguinal region. On the other hand the advantages are as follows: —(*a*) it relieves any obstruction that may be present, and may allow of the general health of the patient being greatly improved by good feeding before the more severe operation of removal is undertaken. This point was well exemplified in the last case, where it was not thought safe to embark on an extensive operation owing to the very weak condition of the patient on admission into hospital; (*b*) it allows a thorough examination to be made of the tumour and its connections, and shows the presence or absence of enlarged glands or secondary growths in the liver; (*c*) it allows of careful cleansing of the rectum by washing out the lower bowel before the second operation, and therefore diminishes the risks of sepsis during the operation; (*d*) it prevents the passage of fæces through the operation area, and therefore diminishes the risk of the occurrence of sepsis after the operation; and this is one of the most important causes of the operative mortality; (*e*) lastly, if at the second operation it is found impossible to unite the two ends of the bowel, an inguinal anus is more convenient for the patient than a sacral one, and after a time the patient may gain some, if not complete, voluntary control over it, if the bowel has been brought through the separated (not cut) fibres of the abdominal muscles.

As regards cases where the growth has extended beyond the limits of removal, by the performance of a timely inguinal colostomy, not only may the patient's life be prolonged but in addition his pain and discomfort may be greatly reduced by diverting the flow of fæces from the ulcerated surface, and by the topical application of soothing or antiseptic lotions. Again, the possible onset of acute obstruction, a common fatal complication, is prevented. If this operation is decided on, it should be done as soon as possible, and the surgeon should not wait for the onset of symptoms of acute obstruction, as colostomy, which normally is a comparatively trifling operation, is under these circumstances attended with a considerable mortality.

The last point we have to consider this morning is that of prognosis. As I have already told you this is unfortunately not as good as one could wish, either as regards immediate or remote prospects. There is not only a considerable mortality from the operation but there is also a large number of recurrences, not usually in the form of local growths, but more often as secondary deposits in distant fiscera, especially the liver.

The main dangers of the operation are :—(*a*) Shock from the severity of the operation in a patient who is worn out from pain, loss of sleep, septic absorption from the ulcerated bowel and inability to take sufficient nourishment, or possibly the complication of acute obstruction. This danger can be largely overcome by careful treatment of the patient before operation, and in some cases by the performance of a preliminary colostomy; (*b*) the onset of peritonitis due to infection of the peritoneal cavity, either at the operation or immediately afterwards, as in the sacral operation the peritoneal cavity is practically always opened. This danger may be almost entirely eliminated by care during the operation, and by stitching the peritoneum around the upper end of the bowel, so as to shut off the general peritoneal cavity; (*c*) sepsis from infection of the large wound resulting from the operation or sloughing of the bowel; this may be largely, if not altogether, avoided by the technique of the operation, by careful drainage and packing of the wound, and by the prevention of tension on the upper end of the bowel and careful preservation of its blood supply, also, as I mentioned above, by the performance of a previous colostomy.

The dangers of recurrence can only be lessened by careful and complete removal not only of the rectum, but also of the tissues between it and the hollow of the sacrum, and by the earlier recognition of the disease, which will allow of operation being performed before infection of the glands and liver has occurred.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Sydney Stephenson, M.B.Edin., F.R.C.S., Ophthalmic Surgeon Evelina and North-Eastern Hospitals for Children, Kensington General Hospital, &c. Subject; "Congenital Anomalies of the Eye."*

ORIGINAL PAPERS.

THE JUSTIFICATION FOR

ARTIFICIAL DILATATION OF THE CERVIX

TO HASTEN DELIVERY AT FULL TERM, WITH A DISCUSSION ON THE MOST APPROPRIATE METHOD OF PROCURING THIS DILATATION. (*a*)

By ROBERT JARDINE., M.D., Edin.,

Professor of Midwifery. St. Mungo's College, Glasgow, &c.

In opening the discussion Prof. Jardine said that the first part of the subject, viz., the justification of the operation, need not occupy much time. The operation had been in use for such a long time that it might be maintained that it was justified by use and want. No justification was necessary for an operation which enabled one to save life. Undoubtedly conditions occasionally arose where, in the interest either of the mother or the child, or of both, a quick delivery was necessary, and, if that delivery was to be carried out through the natural passages, artificial dilatation of the cervix was necessary. A case of unavoidable hæmorrhage might be taken as an instance where the operation was called for in the interest of the mother. In the interest of the child the operation was justifiable in a case of prolapse of the cord early in labour when it was impossible to replace and keep the cord up. While the operation was perfectly justifiable under certain conditions it was occasionally done when there were no just reasons for its use. He strongly protested against this.

The most appropriate method of procuring dilatation.—He first described the methods which approach nature's way by means of hydrostatic bags or the vaginal plug. These methods were slow, and uterine action was called into play by them. Of the bags he considered the firm ones, like Champetier de Ribes, to be more useful than the rubber ones of Barnes. He had found the vaginal plug most useful in placenta prævia, but the plug required to be properly inserted or it would do more harm than good.

Manual and bi-manual methods were next described. Manual dilatation was the one most frequently employed, and was most useful when the cervix was soft and partly dilated.

Dilatation by expanding instruments.—These instruments, like Bossi's, acted much like the hand, but the arms were not sensitive and therefore gave no indication when the parts were being torn. These screw instruments required to be used with great care, and at least half an hour ought to be occupied in the operation. If the cervix was not taken up very great caution was necessary.

Cutting methods.—Multiple incision of the cervix, as recommended by Dührssen. The cervix should be obliterated. The number of incisions varied from two to seven. There was risk of the lateral incision extending so as to cause injury to the uterine arteries, and in making the incisions one should avoid the lateral position and especially when making four incisions. The child should be delivered at once, preferably by forceps, and after the placenta was away the cervix should be drawn down for careful inspection. If there was bleeding the incisions should be stitched, but if there was no bleeding stitching was not absolutely necessary.

Vaginal Cæsarean Section.—Dührssen's name was also associated with this operation, but he had not been the first to perform it, although he had been the first to suggest it.

Effacement of the cervix was not necessary and it was preferable that the presenting part should not have been engaged, as version was the method of delivery usually adopted. One very essential condition was that the uterus should be mobile, so that the cervix and lower uterine segment could be pulled well down.

He described the operation, and also Dührssen's perineo-vaginal incision to enlarge the vagina. He did not think this incision necessary, as the vagina could be dilated manually. It had been maintained that the operation was a very easy one and quite free from risks. Occasionally even an expert would find it a difficult operation to perform, and the not inconsiderable number of cases published amply proved that it was not by any means free of risk. The risks were (1) infection, which was common to all operations, but less in vaginal than abdominal ones; to guard against it the strictest asepsis was necessary. (2) Injuries to mother or child; the uterus might be ruptured by extension of the incision, and the bladder had been injured. In regard to the child it had been born dead, and men had even found craniotomy necessary. (3) Hæmorrhage; this was fairly common as the uterus was usually atonic; in all cases it was necessary to be prepared to tampon. He considered that vaginal Cæsarean section was an operation for experts in vaginal surgery, and not one which an ordinary general practitioner could undertake.

(a) Abstract of Opening Address for discussion, Section of Gynæcology, Exeter Meeting, British Medical Association, 1907.

In conclusion, Prof. Jardine said that in deciding on the proper method to adopt the attendant had to consider the condition of the cervix, and also the amount of his experience. If he were an adept in vaginal surgery he would probably prefer vaginal Cæsarean section in all cases in which there was likely to be difficulty in dilating the cervix, but if he had had no experience in that form of surgery, in the interest of his patient, he should adopt one of the other methods, or else call in the assistance of an experienced colleague who could undertake the major operation of vaginal Cæsarean section. In reference to this operation in cases of placenta prævia he was of opinion that, like ordinary Cæsarean section, it was quite uncalled for, as better results could be got by other methods.

CONTAGIOUS DISEASES AND SCHOOL ATTENDANCE. (a)

By SIR SHIRLEY MURPHY, M.R.C.S.,
Medical Officer of Health.

THAT attendance at school should be compulsory is inevitable under the conditions of our civilisation, that this attendance involves increased risk of exposure to infection is undoubted, hence the duty of the State to protect the child from risks incidental to an act of enforced obedience is a moral obligation. Our object in meeting in this room is to endeavour to learn how this protection may be best afforded with the least interference with the primary intention of the child's attendance at school, or how this primary intention may be best effected under conditions which reduce to a minimum the risk to which the school-attending child is exposed. In our study of this subject we are at once confronted with the fact that the risk of infection to the school child in the school is only part of the whole. In endeavours to control the spread of infectious disease in the school it is impossible to ignore the conditions which prevail in the home. In efforts to limit the occurrence of infectious disease in the home we must have regard to the opportunities of infection which occur in the school. In England, until recently, the Education Authority has been separate from the Health Authority, and difficulties which have stood in the way of organised administrative effort have been great. Probably nowhere were the results more manifest than in London during the epidemic of diphtheria which prevailed, especially in the six years 1892–7, during which some 15,000 children lost their lives. In such matters division of administration involves the weakening of the machine. Two separate bodies, even with the best intention, do not accomplish that which would be effected by one body endowed with the powers of both.

In England the difficulty is being met by the constitution of the Health Authority as the Education Authority, and this has in it the basis of an effective machine. The Health Authority has, however, not always been provided with the necessary machinery to effect the object in view, and this machinery must be developed and adapted for the new work which it is required to undertake. Changes are slow, and some mistakes are made, but in the end the true issues are usually seen, and progress in the right direction is made. The guiding principle must be that the administration which is designed to protect the health of the population at "all ages" is that which must be concerned with the health of the child at school age, whether in the school or in the home.

The question may well be asked, To what extent does attendance at school contribute to the number of cases of infectious disease in the population? The information required to answer this question is scanty, but some indication of the extent of this contribution is afforded by a comparison of the number of cases occurring in holiday periods with the number occurring in periods when children are attending school, and in this connection I might cite the figures arrived at by comparing the number of cases of scarlet fever and diphtheria which actually occurred in the month of August during the ten years 1895–1904, with the number of cases of scarlet fever and diphtheria which would have occurred in London in that month had the schools remained open instead of being closed, this latter figure being arrived at by estimating the cases for the month of August from the actual notifications in the two preceding months of June and July and the two succeeding months of September and October. The difference between the actual and the estimated cases is in respect of scarlet fever 3,974, or 27.6 per cent., and in respect of diphtheria 2,002, or 23.3 per cent.

A legitimate criticism of these figures would be that they may be due not to actual decrease in opportunity of infection during the school holidays, but to—(*a*) diminished population in London, owing to the exodus of young persons at the time of the August holiday, or (*b*) the system of notification being less operative during the summer holiday, owing to the children being less under observation than during the period they are attending the schools, or (*c*) to a combination of both circumstances.

On these points I may observe that with regard to (*a*) much the same decrease is observed in the August holiday among the child population of those places in the country to which the London population resorts at the time of the holiday. On turning now to (*b*) it must be admitted that the notified cases of infectious disease in these places would experience somewhat similar diminution if the decrease were due to the cessation during the holiday of observation of children in school.

Concerning this point of criticism I may, however, point out that the decrease of notified cases of infectious disease in children of school age is often followed a week later by decrease of notified cases of infectious disease among children of a younger age than the school age, suggesting very strongly that there has been diminished opportunity for these younger children to acquire infection from other persons, and this finds its most ready explanation in actual decrease of infectious disease among children of school age.

My own view is that there is decrease of infectious disease among children of school age as the result of closure of the schools during the summer holiday, and that the figures given above represent substantially what that decrease has been, or, in other words, the proportion of cases of infectious disease which at that period of the year was due to the opportunities of infection from person to person as the result of aggregation of children in school. In any attempt to estimate the proportion of cases of infectious disease which during the whole year may be due to this circumstance, it is necessary to recollect that in the autumn months both scarlatina and diphtheria show a marked increase of prevalence, and it may be that there is an ability of the disease to spread in school at that time which is greater than its ability at other times. If this be the case, the actual proportions of cases in the whole year due to school attendance would be less than is suggested by the figures given above.

The facts, however, go to support the view that prevalence of disease is maintained by inconspicuous cases, whether mild and unrecognised cases, or by cases of persons who, having no symptoms of their own, are merely "carriers," with an ability to infect susceptible persons.

Hence arise our difficulties in dealing with infectious disease in schools, the difficulty of detecting exceedingly slight cases of disease, the still greater difficulty of detecting "carrier" cases.

Obviously, any child who is suffering from an ailment that raises question of infectious disease should be at once excluded from the school, and inquiry should be made as to the nature of the malady. In this matter the teachers can and do render invaluable service.

(a) Introduction to Discussion at International Congress on School Hygiene. London, July, 1907.

and the extent to which they exercise watchfulness over the children under their charge will often determine whether disease is limited to a single child or whether it spreads to other children. Again, the exclusion of children coming from infected homes is a principle which is generally accepted, although certain modifications in the applications of this principle are possible in practice, owing to differences in the behaviour of the various infectious diseases which commonly affect school children.

In dealing with outbreaks of infectious disease in schools, the question will always arise whether dependence should be placed on the exclusion of particular scholars, or whether the closing of classes or schools should be resorted to. This is a subject which will engage the serious attention of this Section, and it may be hoped that the papers which will be read will contribute to the knowledge required for determining under what circumstances " exclusion " or " closure " should be adopted. Where bacteriology can be employed, as in the case of diphtheria, the first of these methods is largely adopted, and hopes are held out that the complete examination of material from the throats of the children attending an invaded school, and the exclusion of all children harbouring the Klebs Loeffler bacillus may suffice without the more extreme step of closing the class or the school. To determine whether this will prove to be sufficiently effective at all times, at the height of an epidemic, as well as at times of smaller prevalence, further experience is needed. Results which are obtained during the decline of an epidemic cannot always be relied upon as affording sufficient ground for inference that the same method will be equally effective at a time when diphtheria in a community is rapidly increasing in proportion ; but, however this may be, there is no question that ample provision should be made both in respect of bacteriological laboratories and in staff for complete enquiry into the condition of the children attending the invaded school. The more thoroughly this work can be done the greater is the hope that the exclusion of particular scholars will suffice. Other considerations have to be held in view to determine whether the school shall be closed, especially when other diseases are concerned which cannot thus be dealt with. Beyond the question of the extent to which the school is invaded there remains the further question of the proportion of children attending the school who are susceptible to attack. As the result of previous recognised or unrecognised attack, and as a result of natural immunity, there must be a considerable balance of children who are safe from further risk of infection. If we were to judge from the number of cases of scarlet fever which are notified we do not find evidence that any large proportion of London children suffer from this disease. Thus, taking the experience of London during the ten years 1897-1906, we may learn approximately that of children under ten years of age living in 1906 only 63.8 per 1,000 had been attacked ; among those at the other ages being under nine years, 57.5 ; under eight years, 50.4 ; under seven years, 42.2 ; under six years, 33.9 ; under five years, 25.2 ; under four years, 17.2 ; under three years, 10.4 ; under two years 5.2 ; under one year, 1.7 per 1,000. Notified cases, however, provide an incomplete basis for estimating the proportion of children who have passed through an attack of the infectious diseases, and we can in no way assume that the balance represents the number of susceptible children remaining. In some degree the number of modified cases is swollen by cases notified in error, but, on the other hand, not all the cases of recognised infectious diseases are notified, and still more certainly, only a proportion of the actual cases which occur are recognised. Further, it is common experience that only a proportion of the persons exposed to infection are attacked, even when, so far as can be known, they have never before suffered from the malady ; hence nothing but actual experience can show what infectious disease will do if left unchecked in a class or school of children of any particular age. On these points interesting material will be placed before the Section.

In view of the special incidence of infectious disease upon children in the first few years of life, the question of the age at which these children should be required to attend school is a subject well deserving of study, and will be before this Section. In England the age of compulsory attendance is five years, in Germany it is one year later. An examination of the statistics of infectious disease of communities having a different age for attendance should throw some light on this subject. If the age of attendance be deferred, protection from attack of school-derived mealses would obviously not be extended to every child under that age. If older brothers or sisters contracted measles in school, they would bring the disease home to younger brothers and sisters, although these younger brothers and sisters, if they themselves attended school, would have the additional risk of exposure to measles in the school itself. It is, of course, the family of a single child which would derive the most benefit. How would deferred school attendance show itself in the statistics of infectious disease ? It is quite likely it might be manifest in the case of scarlet fever and diphtheria, and but little, if at all, in the case of measles. The subject is well worth inquiry, which, of course, should relate to each of the diseases with which we are concerned, inasmuch as they do not manifest the same degree of infectivity. Unfortunately, it is the usual practice to group for the purposes of publication all cases occurring from five to ten years of age, and here I may make an appeal to those who have the tabulation of these figures that, whether published or not, the number of attacks and the number of deaths should be separated for each year of life so as to be available to determine statistically a question of this sort. However, " the lower age limit of school attendance " will be before us from the pen of an especialy able writer, and the need for the proposal I have made may be better determined after we know the contents of this paper. Under all circumstances we may bear in mind that if the age of attack is deferred it results in a lessening of the fatality of the disease and that, if postponement of age of attendance at school leads to postponement of age of attack, the result will be a saving of child life.

I have made no mention of prophylactic inoculations but I may say that the value of vaccination as a preventive of small-pox needs no mention here. Experience of the use of antitoxic serum as a prophylactic in schools is much more limited, but good results have been claimed for it.

One of the advantages of school attendance is the opportunity which is afforded for dealing with all conditions of health of that part of the population which is of school age, whether they affect life or only cause inconvenience. Hence, the parasitic diseases of the skin, trachoma, &c., are included in our programme. Of these I need say nothing more than to insist on the great advantage to the population which would result from a systematic treatment of all children who suffer from contagious maladies of this sort. There should be no difficulty in the practical eradication from the population of all such conditions if the work is seriously undertaken in connection with the children who are brought under observation in the schools and if the work be followed to the home where the younger children are found. In the same way it may be pointed out how much may be done for the cure of pediculosis. A condition of this sort ought not to be tolerated in a civilised community, and school attendance gives a claim for interference with this condition in the child population.

A BIRD'S-EYE VIEW OF NEURASTHENIA.

By M. MARC., M.D.,

Professor of the Faculty of Medicine, Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

If the term neurasthenia had not been distorted from its original meaning, if under this title there were no tendency to describe a definite disease of the nervous system, no term could be more appropriate as applied to certain nervous states.

Unfortunately, and especially in neuropathology, physicians cannot resist the temptation to systematise, to create morbid entities which, once promulgated, are erected into absolute dogmas. Neurasthenia is a curious example of this regrettable tendency of the human intellect.

Formerly authors used to describe under the name nervousness all nervous states not dependent upon lesions of the nerve centres, and manifested by very diverse features, the only characteristic feature whereof was indeed their abnormality. Hysteria, for instance, was a form of nervousness. Some very suggestive contributions, cleverly handled by Beard and, later, by Charcot, rendered it necessary to distinguish between hysteria and neurasthenia, and by artificially grouping the symptoms of nervousness they succeeded in building up two special diseases of the nervous system, two neuroses capable of identification by their respective stigmata. The morbid picture was so admirably drawn that it was universally accepted, and forthwith everybody was on the look-out for neurasthenic subjects, with a large measure of success, for plenty of persons presented the typical stigmata evoked by the interrogative suggestion of the examiner.

Beard, in order to explain how it was that such a striking disease could previously have escaped recognition, admitted that neurasthenia was a new disease caused by the complexity and overstrain of modern society. It is odd to notice that the same explanation has been given of the prevalence of appendicitis, which we learned from the works of Sir Frederick Treves, and of the tabetic arthropathy which was unknown before Charcot called attention thereto.

But observers soon found themselves hampered by the narrow limits assigned by Beard. They were, to begin with, obliged to admit that hysteria, this other "one and indivisible" disease, was sometimes associated with the other neuroses and Charcot conceded the existence of hystero-neurasthenia, just as, since his time, we speak of hystero-epilepsy. The distinguishing features of neurasthenia were so commonplace that they cropped up everywhere. Neurasthenia was for the nervous system what influenza was for the respiratory tract, the disease responsible for everything, which would explain everything. Then specialists took to describing special forms of neurasthenia, and we were treated to dyspeptic neurasthenia, cardiac neurasthenia, syphilitic neurasthenia, gonorrhœal neurasthenia, and so on.

In short, the unduly narrow limits of neurasthenia gave way on all hands, and after having been the fashionable disease, neurasthenia has comparatively fallen into abeyance and is less frequently invoked. Professional opinion has gradually undergone an evolution, and neurasthenia is no longer regarded as a special disease, but rather as an abnormal state of the nervous system, characterised more particularly by inadequate reactions and a tendency to depression. Like the hypochondriacs of former times neurasthenics are usually depressed, tiresome and tired, complaining of everything, and more alive than their normal fellows to all kinds of disagreeable sensations and impressions, so much so as to make mountains out of mole-hills. The loss of will-power renders them unable to resist these auto-suggestions or to throw them off; in short, their nervous system is inadequate, lacks spring, and is asthenic. As suggested above, no term better describes their plight than the word neurasthenia, provided no very exact meaning be attached thereto.

Neurasthenic patients only present one feature in common, viz., nervous asthenia, but no one symptom or stigma is always present. No two patients differ more than two neurasthenics, and nothing equals the variability in course and duration of the neurasthenic condition.

The gravity of neurasthenia depends upon its cause, and we may divide these patients into two principal classes:

(1) Constitutional neurasthenics who have been so from their infancy and will continue so till they die. They have inherited a sort of functional malformation of the nervous system due to parental strains, they, are usually the offspring of neurasthenic, epileptic alcoholic or morphinomaniacal parents. Everything tends to aggravate the neurasthenic state in these subjects, and no sooner is one manifestation cured than another takes its place.

(2) Accidental neurasthenics. A violent moral or physical shock, a painful emotion, a traumatism, an attack of disease, an intoxication, or mere overwork may determine neurasthenia in any individual previously in good health. These, however, do not long remain in a state of neurasthenia, but soon recover under treatment. The nervous system, depressed for the time being, reasserts itself under the influence of rest, hygiene, etc., or after the disappearance of the disease to which it was secondary.

This is the origin of the neurasthenia that attacks young people who have worked too hard for examinations, or business men whose occupations have been too much for them, or persons who have been smitten in their affections or have been bereaved, or who have been subjected to intense disappointment or who have been in a railway accident. The same remark applies to the victim of poisoning—tobacco, lead, syphilis, tuberculosis, dyspepsia, etc. The depression is fully explained by the cause, though in some instances the result may be altogether out of proportion to the apparent cause and may, moreover, have disagreeably persistent effects. This, however, is only the case in persons predisposed thereto, so that the neurasthenia in such persons is more constitutional than accidental, and the cure is consequently relative and not absolute.

Neurasthenia hardly lends itself to a general symptomatic description. Each individual has a neurasthenia of his own. The common character of impotence, inadequacy and depression is present in all, but the nervous disturbance bears on this or that part of the body, according to the local predisposition or lessened resistence. Every morbid symptom, every painful sensation, is enhanced and rendered more persistent by the neurasthenic state.

In neurasthenia we only get subjective symptoms which do not admit of verification. The disease consists in the patient being acutely conscious of a number of minor ills to which the healthy individual would not condescend to pay attention. When we examine a neurasthenic subject everything lies in his narrative, nothing abnormal can be detected, yet he takes immense pains not to overlook the most insignificant detail. One patient insists on his headache, his neuralgia or his tremors which no one else can detect, while another emphasises his constipation and his multiple abdominal sensations. They will not willingly spare the physician a single detail, we have to take cognisance of all the analyses of urine and, if of some standing, the patient will produce a sample of urine ready for examination along with a sample of fæcal matter.

As a general rule neurasthenics complain of persistent headache which sets in on rising, compresses the forehead and skull like a helmet, spreads down the occiput and neck, is exasperated by work, noise and light, is accompanied by giddiness, noises in the ears, disturbances of vision and, in some instances, by hyperæsthesia of the scalp. He constantly feels weary and rest does not bring any relief. They feel so limp that they would prefer not to get up or walk or go out. They get attacks of fatigue quite suddenly, following an emotion or a worry or even without any obvious cause. They complain of aching in the back, or dorsal pain. The rachialgia, which is characterised by a sensation of pressure or compression, is generally increased by pressure on the spinous processes; the skin may even be hyperæsthetic, and they declare themselves unable to bear the weight of the clothes. The back pain is most marked at the lower part of the spinal column and the "sacral patch" is one of the classical signs.

The digestive disturbances have been specially investigated by Bouveret and Mathieu. Usually the condition is one of gastro-intestinal atony, the appetite is capricious and poor, the patient feels hungry and cannot resist the sensation without feeling faint, so that he eats at all times. At table, however, after the first few mouthfuls he has had enough. He feels better after a meal, but this does not last long for he soon complains of a feeling of weight in the epigastrium, of swelling of the stomach, of eructations, flatulence and palpitation, and he feels drowsy. Constipation and muco-membranous entero-colitis often accompany this morbid condition. The state of the gastric juice is variable, sometimes the secretion is insufficient and poor in hydrochloric acid, in others, on the contrary, there is hyper acidity.

The gastric troubles are most pronounced in the grave cases in which the patient becomes emaciated and loses strength, and we are tempted to think of cancer.

Insomnia is of frequent occurrence. The patients are a long time in getting to sleep and awaken in a mental state of excitability or even anxiety. They get to sleep again with difficulty and often have disagreeable dreams.

The principal psychical trouble consists in a diminution of the personality with enfeeblement of the mental faculties, inability to concentrate the attention, and a tendency to sad thoughts. The emotions are not under control, and the memory is impaired. The will-power is almost completely lost, so that the patient is incapable of arriving at the most trifling decision, even in regard to his ordinary occupations or habits of life. Every act is a burden to him, he hides himself from everybody and everything. Unable as he is to fix his attention he cannot read or work, and his conversation is incoherent. He often experiences unnecessary apprehensions, he thinks he is suffering from some dreadful disease, and it is very difficult to get these ideas out of his head.

In addition to these general symptoms we get certain secondary manifestations, such as continuous or intermittent giddiness. This is relieved by rest in bed and by taking food, but not always. It may be accompanied by a dazed feeling with disturbances of vision and noises in the ears, in fact, the syndrome of Menière. The patient complains of cramps, of fibrillary contractions of the muscles, twitching of the eyelids and trembling of the hands. The hyperæthesia may be limited to some part of the body, but is most frequently localised in the scalp or over the sacrum. Such patients may complain of every conceivable painful sensation. Sight might appear to be disturbed, the eye quickly tires, the image becomes blurred and the patient experiences painful distension of the globes as soon as he attempts continuous work, yet ophthalmoscopic examination of the eyes shows them to be normal.

The genital organs are frequently incriminated, such patients suffer from nocturnal emissions which disturb and alarm them, and they are devoured by the terror of becoming impotent.

Attacks of palpitation supervene under the influence of some trifling emotion or fatigue, the patient thinks he has heart disease, and is dissuaded from that belief with the greatest difficulty. His apprehensions are sometimes intensified by persistent tachycardia, irregularities of the pulse or attacks of pseudo-angina. Urinary symptoms may be present. There may be pollakiuria or urethral smarting. Phosphaturia has often been mentioned among the symptoms of neurasthenia, but that is a mere error of diagnosis. The presence of a phosphatic deposit in the chamber is not due to excessive elimination but to precipitation consequent upon the reaction of the urine or to an insufficiency of the aqueous vehicle. Demineralisation and leakage of phosphates have never really been met with except in presence of emaciation.

The diagnosis is easy; too easy indeed. The physician must be careful not to label as neurasthenic disturbances due to disease of the heart, stomach or lungs. We must never proceed on the strength of a mere statement, but must examine the patient thoroughly in order to make sure that the apparent neurasthenia does not mask some organic trouble. Certain persistent headaches, with loss of memory, change of temper and mental depression may usher in general paralysis, but if these symptoms are associated with inequality of the pupils and impaired reflexes lumbar puncture will enable us to make the distinction. Headache and vertigo may be due to cerebral tumour or to syphilis, as can be ascertained by careful examination and close observation of the exact symptoms. Pain in the limbs with persistent weakness and dulled reflexes may be indicative of tabes, but the Argyll Robertson pupil, the abolition of the reflexes and Romberg's sign will put us on the right track.

The diagnosis may sometimes be rendered difficult by the fact that the symptoms of the organic affection are at times very ill-defined and that such affections often give rise to neurasthenic manifestations: in short, we must learn to detect the organic lesions behind the neurasthenic mask.

We must likewise display a judicious scepticism in respect of all elderly *soi disant* neurasthenics who complain of inability to work, dyspeptic troubles, vertigo, headache, palpitation and feeling of numbness, because the examination of the urine, the heart and the large vessels will in some cases enable us to identify Bright's disease or arterio-sclerosis.

Lastly, we must be careful not to diagnose as cases of neurasthenia certain states characterised by languor with anæmia and loss of appetite and strength supervening in young subjects, for these signs may be merely the manifestations of latent tuberculosis.

In short, we must not be in a hurry to formulate a diagnosis of neurasthenia; this should always be very guarded indeed; it should be considered rather as a refuge for the destitute, that is to say, merely the result of our inability to discover any organic lesion capable of determining neurasthenic symptoms and even in constitutional neurasthenics we must always make careful research for affections likely to give rise to the neurosis.

Neurasthenia is always very difficult to cure when it is not purely accidental. The first indication in the treatment is to attack the underlying affection: treat the syphilis, stop the overwork, calm the emotions and so on; that is the real way to overcome certain types of neurasthenia.

Hygienic measures constitute the basis of the treatment. The patients should avoid undue fatigue, they should be incited to take regular, graduated, physical exercise in the open air, and in most instances a period of rest treatment at a certain altitude is indicated. Hydrotherapy in the form of douches and baths is of service, hot for excitable subjects, cold for the depressed. Wet packs, rubbing with alcohol and cold salt water baths, general massage and local massage in certain painful manifestations, statistical or faradic electricity, are all valuable in their way.

Medicinal treatment plays a secondary part, but nervous sedatives and soporifics are useful to subdue the nervous excitement, ensure sleep and allow of rest. Stimulants, such as strychnine, arsenic and phosphates are useful adjuvants, whether they act as tonics or by suggestion.

Every prescription must be accompanied by cheerful encouragement, for the moral influence of the physician is of the highest importance, though truly it entails much patience, tact and persuasion.

In obstinate cases the treatment of neurasthenia cannot be carried out at home; the patient must be withdrawn from his usual environment in order to disassociate him from his preoccupations, and he must be isolated in a nursing home or he may be sent to a health resort in the mountains with rest, massage, electricity and a special dietary. These are the main features of the Weir Mitchell treatment now adopted by all specialists in this department.

The Committee of the National Association for the Establishment and Maintenance of Sanatoria for Workers Suffering from Tuberculosis are about to open the second half of their main building at Benenden, Kent, which will accommodate 68 patients.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Chlorosis and Early Tuberculosis.

By Leonard Williams, M.D., M.R.C.P.,
Assistant Physician to the Hospital; Physician to the French Hospital in London.

This girl, whose age is 17, has been to see us three times. On the first occasion she was obviously and grossly anæmic, with that peculiar tinge about the face which has given rise to the name of "the green sickness." We examined her heart, and found that it was substantially normal, there was no albumen in her urine, and we were therefore justified in provisionally labelling her case one of chlorosis. There was, of course, a history of scanty and irregular menstruation. That is so common in these cases that it may almost be regarded as a symptom. In this case the scantiness had proceeded to the point of complete suppression for the last two months. Another almost invariable accompaniment of the condition is constipation, and another very common association is carious teeth. This girl's teeth were not carious, but she was constipated. She was given a medicine containing ferri ammon. cit., 15 grs.; liq. arsenicalis, 3 minims; tinc. nucis vom., 4 minims; and water to half an ounce, three times a day, together with an aloes pill to be taken in the course of the afternoon. Aloes is always the best form of aperient to exhibit in these cases, because in some obscure way it seems to heighten the effect of the iron.

On the occasion of her second visit she was improved, but not markedly so. The constipation was better, but her anæmia, though less, was still very pronounced. The dose of the iron was therefore increased to 20 grs., and that of the arsenic to 5 minims.

She comes to-day still slightly improved, but the result is disappointing. Iron and arsenic in cases of pure chlorosis may be regarded as specific, and if they do not cure a case of this kind, then either we have combined our drugs badly, or there is something else the matter with the patient.

In this girl's history there is one factor of rather sinister significance. I have said that in chlorosis menstruation is liable to be irregular and scanty, but it is not very often totally suppressed. Total suppression of the menses has been described as one of the earliest signs of tuberculosis, and I need hardly remind you of Trousseau's saying that an anæmia which resists iron is probably due to tubercle. These two factors being present in this case were sufficient to arouse the suspicion that the "something" which was preventing this girl from reacting to iron was a tuberculous invasion. We therefore searched for other signs.

A very early sign of tuberculosis is tachycardia, which, as I have often previously explained, is due to vaso-dilation, which may be regarded as one of the physiological effects of the tuberculous toxin. Now this girl's pulse is no less than 120 per minute in the upright position. It falls to 90 when she is recumbent—that means that the vessels are unduly dilated. We have therefore three facts to go upon—a chlorosis which resists iron, suppressed menstruation, and tachycardia. These three in themselves, though not serious, are distinctly disquieting.

The girl, you will observe, has very little pigment in her hair. That in itself is sufficient to excite a certain amount of suspicion, and some of you may have noticed, when I was examining her chest, that she had a line of fine down passing from the hair of her head to between the scapulæ behind. That, according to some people, is another sign to be viewed with apprehension.

The examination of the chest revealed nothing very definite. There were the differences between the right and left apices which are so often found in perfectly normal people—that is to say, the right side was rather less resonant than the left, and the voice conduction was rather better. The breathing on the right side did, however, present an abnormality which it is difficult to describe, but which has been called "harsh breathing." It is not that such breathing is necessarily high-pitched, or that it has any of the characters of what we call bronchial breathing, but it is harsh. It offends the ear, so to speak, and is in very marked contrast with the weak breathing which is to be found on the other side. Though I listened carefully I could not find anything in the nature of cog-wheel breathing. The examination of the chest, therefore, has given us no very strong confirmatory evidence.

How are we going to set our suspicions at rest? Well, if we take the girl into the wards and record her evening temperatures, we shall probably find something very definite to go upon. We shall probably find, that is, that she has a slight evening rise—a rise not sufficient to cause her any discomfort, but one of which the thermometer will tell us in unmistakable terms. The chart may be expected to show us that, though her temperature is possibly sub-normal in the morning, it rises to a degree, or a degree and a half, above normal in the evening. This is a very important point, and in suspicious cases it is one which should always be carefully investigated.

Another confirmatory sign is to be found in the ulnar reflex. When we made this girl stand at the table with her fore-arms resting thereon, and the arms flexed at the elbow, you saw that when I drew a pin smartly along the ulnar surface from elbow to wrist, there ensued a wrinkling of the hypo-thenar eminence, due to a contraction of the abductor minimi digiti, and that this phenomenon was present on both sides. Now this ulnar reflex is not pathognomonic of tuberculosis, but its presence affords very strong confirmatory evidence of suspicions otherwise aroused. Like so many other of these reflexes, its absence means nothing. It is often absent in advanced cases of phthisis, especially in men who have worked with their coarser muscles rather than with their finer. It is more easily elicited in women on account of the better development of the abductor minimi digiti which constant use of the finer muscles of the hand naturally gives rise to. This ulnar reflex is occasionally present in some other conditions, but it is on the whole very rare except in tuberculosis. In a person of the age of this patient its presence affords evidence which it is very difficult to gainsay.

Further confirmation could, of course, be obtained by examining the sputum for tubercle bacilli, but inasmuch as the patient has no cough, it would be very difficult to obtain sputa coming from the lungs themselves. Any sputa that she produced would probably be salivary only. Nevertheless it is our duty to see if such an examination will help us.

Another laboratory method which is now deservedly attracting a very considerable amount of attention is the estimation of the opsonic index. That, fortunately, is a comparatively easy matter, and before she leaves the hospital this girl will go to the laboratory for the purpose of allowing us to ascertain what her opsonic index is.

You may be inclined to say that the foregoing constitute a very flimsy basis whereon to construct a diagnosis of so grave a condition as pulmonary tuberculosis; but the time has now gone by when, before commencing treatment, we used to wait until there was an involvement of the pulmonary area so definite that it was accessible to ordinary percussion and auscultation. If we wait for the classical physical signs before commencing treatment, then we have waited too long. Phthisis is, no doubt, under entirely favourable circumstances, a very curable disease, but the condition precedent to its curability is its detection in the very earliest stages.

It is now our business, therefore, to look for signs of tuberculous invasion which were formerly relegated to positions of minor importance. The laboratory methods to which I have just referred happily afford us an amount of assistance which in the large majority of cases reduce suspicion to a certainty. This patient I believe to be suffering from commencing phthisis. Her opsonic index, when we know it, will set the matter at rest, and it is even possible that the examination of the sputum may also confirm the suspicions which her general condition has aroused.

Now, if we are to cure this girl, how are we to set about it? If I were to ask this question of you individually, each one would certainly say "send her to a sanatorium." Unfortunately it is not very easy to get girls from the out-patient room of the hospitals into sanatoria; and even when we succeed we are not able to select the sanatorium into which they shall go. Assuming that the methods of treatment are substantially the same in all sanatoria—and I think that nowadays such is a reasonable assumption—there is one factor in the situation which is of the very highest importance, which unfortunately we are not in any way able to control. This factor is the climate of the place in which the sanatorium is situated. There are, as you know, bracing and sedative climates, and in private practice the success or otherwise of a sojourn in a sanatorium may depend largely upon the suitability of the climate in which the selected institution is situated. The circumstances which lead us to select one climate rather than another in an individual case are so complicated that I cannot even outline them here. I may, however, say that young people, about the age of our present patient, do best in a climate which is neither too sedative nor too bracing, and that the older people grow the more sedative should be the climate to which they are advised. There is a certain type of lymphatic tuberculous person, generally young, who does so surprisingly well in bracing climates, such as that of Margate, that one is apt to think there must be something specific against tuberculosis in climates of that type. Against this pitfall I wish you particularly to be on your guard. The results of Margate in suitable cases approach the miraculous, but in unsuitable cases such a climate will frequently send a patient downhill with a rapidity which is truly alarming.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

Amputation of Thigh for Senile Gangrene. Lumbar Analgesia.—Mr. Edred Corner operated on a woman, æt. about 76, who had been admitted with senile gangrene of the right leg extending nearly up to the knee. There was no pulsation in the right anterior and posterior tibial arteries. There was pulsation of the same arteries of the left leg. She had been ill for a fortnight. Her heart and arteries were extensively diseased; in fact, so much so that it would be unwise, Mr. Corner said, to give her a general anæsthetic. It was therefore decided to perform an amputation at the upper third of the thigh, stovain being injected through a lumbar puncture. In this case there was some slight difficulty in performing lumbar puncture because the patient had some osteoarthritis of her spinal joints which caused rigidity of the spine in consequence of which it was impossible to flex the spine and separate the laminæ of the vertebræ. Anæsthesia came on rapidly after the injection and extended nearly up to the nipple line. The amputation was carried out with skin flaps and the patient experienced no discomfort whatever. Both femoral artery and vein were thrombosed at the point of section, but though the main vessels did not bleed, the branches from above bled copiously, therefore showing that there was plenty of blood supply for the flaps. Anterior and posterior skin flaps were cut and reflected then the muscles were divided circularly and retracted, and the bone sawn through a little higher. The steps of the operation were carried out quickly and quietly, the patient's ears having been closed with wool just before the bone was sawn through. The vessels were ligatured and the flaps united without drainage. During the operation the patient conversed freely with the anæsthetist, Dr. Mennell, and declined the offer of a cup of tea, as she said she was not thirsty. Mr. Corner said this case illustrated the uses and advantages of lumbar anæsthesia; it was a method, he thought, which could never be used for general purposes on account of the patient remaining conscious, the headache, pain, and sickness it sometimes causes, and the slight risks which it entailed, such as the occurrence of meningitis; moreover, he had seen it produce severe symptoms, incessant vomiting, and feeble pulse during the period of anæsthesia; in addition, on rare occasions it has failed to produce any anæsthesia, as, for example, in a young man about to undergo an operation for varicocele, when the discoverer of stovain, Professor Fournier, of Paris, was present; but in cases such as the present in which it was undesirable to administer a general anæsthetic, the use of lumbar anæsthesia was invaluable. As a general rule, it produces an anæsthesia which lasts about three-quarters of an hour, and extends up to the ninth or tenth dorsal nerve, so that any operations on the legs or the lower part of the abdomen can be done painlessly. The method of producing anæsthesia by spinal injections, he remarked, has been used in the cervical region to enable operations to be performed on the neck, chest and arms, but its use in this region has never been popular on account of the greater difficulty and danger of the operation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 15th, 1907.

Atrophy of the Tongue.

Lingual atrophy is either total or partial; the former is rare but can be observed in glosso-labio-laryngeal paralysis of bulbar, cerebral, or basilary origin.

The development of the affection is slow and progressive, and commences by paralysis of the tongue, followed gradually by that of the lips, larynx, and pharynx, producing difficulties in mastication, deglutition, and phonation.

The patient salivates incessantly, becomes emaciated, and succumbs after several months.

Where both lingual nerves are paralysed simultaneously, the tongue is atrophied, although the lips and face may preserve their normal mobility. Total atrophy has also been observed in progressive muscular atrophy.

Such are the usual causes of total atrophy of the tongue, which, however, is a very rare affection.

On the other hand, hemi-atrophy is more frequent, and has been observed in cerebral affections, encephalitis, hæmorrhages, softening, &c. But the origin of this curious lesion is found particularly in affection of the bulb. The lesion can affect the nuclei of the lingual nerve from meningitis or pachymeningitis, producing compression and atrophy of centres of origin. According to Ballet, hemi-atrophy of the tongue is seen sometimes at the commencement of ataxia and constitutes an excellent element of diagnosis.

In syringo-myelia, partial atrophy coincides with paralysis of the velum palatum as in all bulb lesions; the same is observed in the course of sclerodermia or tropho-neurosis, and especially observed in the female sex.

Lesions of the lingual nerve, due to traumatism or neuritis, can produce partial atrophy.

Generally, the patients are unaware of the deformity, which is discovered frequently by chance. But, nevertheless it, when recognised, puts us on the track of certain nervous affections, as ataxia, for instance—hence its importance.

Cervical Adenitis.

Dr. Calot, of Berck-sur-Mer, the well-known authority on diseases of children, recommends the following treatment for cases of cervical adenitis, which, when operated upon without precaution or left to themselves, leave behind very unsightly scars.

If the abscess is very ripe, the following should be injected—

Creosote, 4 m.
Iodoform, x. grs.
Olive oil, 1 dr.

If the abscess is not ripe—

Camphorated naphtol, xv. gr.
Glycerine, 1 dr.

The amount injected should correspond with half the cavity of the abscess, so as not to distend the walls. The injections should be made every four or five days, and seven or eight given in all.

If the abscess when first seen is ready to open, a small puncture should be made beneath the tegument, but without injection, and repeated if necessary several days consecutively until the skin has recovered its integrity; then the injections might be given. After the eighth injection, compression is made so as to bring the sides together.

In case of non-suppurating ganglions, general treatment should be prescribed, and the patient counselled to have patience. Warm compresses of salt water might be applied several times a day as a resolvent, while antisepsy of the nasal fossæ, the mouth, and the teeth so as to disinfect all the tributary territories of the ganglions, should be practised with care and perseverance. The patient might also be sent to the country, to the sea, or to the saline waters of Biarritz, Bex, &c.

In very many instances, improvement takes place, and a total cure follows at the end of a few months.

If softening of the ganglion sets in a favourable moment will be awaited to operate as above.

It sometimes happens that the ganglions remain torpid; they maintain their hardness and volume. In such cases, says Dr. Calot, a modifying liquid should be injected into the ganglion. Five or six drops of camphorated naphtol (pure) injected every three days, favours the absorption of the gland, which, at first swells, increases in volume, and then gradually subsides and disappears finally at the end of four or six months. The number of injections to be given are seven or eight, with three days' interval between each injection.

If from six to twenty drops of camphorated naphtol were injected every day, suppuration would set in, and then the usual treatment could be applied.

It is preferable, in general, to provoke the suppuration as a cure is more quickly obtained.

Fortunately, adds Dr. Calot, a cicatrix is much more easily avoided than effaced. It can be almost always avoided by the treatment he recommends. It is true, this treatment requires perseverance and a much longer time than a rapid and brilliant extirpation, but this last leaves an indelible mark, while his treatment cures without a trace.

WARTS.

Apply a thin layer of black soft soap at night to the hands, and dust them with talc or any other absorbent powder in the day time; or,

Sulphur, 5 dr.
Glycerine, 2 oz.
Acetic acid (diluted), 2 dr.

Applied the same way as the soap; or

Salicylic acid }
Lactic acid } ā ā xxx. gr.
Resorcin, }
Collodion, 4 dr.

Touch the warts by means of a brush or the cork morning and evening.

Internal treatment acts on the imagination of the patient and for that reason should not be omitted.

Calcined magnesia, xv. grs. For one wafer to be taken daily; or

Tincture of thuja occidentalis, 4 drs.

Twenty drops three times a day.

WHOOPING COUGH.

Ichthyol, ½ dr.
Syrup, 4 oz.
Peppermint, *q.s.*

Two teaspoonsful daily.

Under the influence of this simple remedy the attacks diminish rapidly and at the end of two or three weeks the child is cured.

Nasal antisepsy by instillations of liquid vaseline and menthol and also intestinal antisepsy by castor oil administered frequently, constitute a good adjunct treatment.

GERMANY.*

Berlin, Sept. 15th, 1907.

AT the Medizinische Gesellschaft Hr. Bickell communicated a note on

THE INFLUENCE OF METALS ON GASTRIC SECRETION.

He said that all metals that gave off hydrogen in dilute solutions of hydrochloric acid stimulated the mucous membrane of the stomach to secretion; for example, iron, manganese, aluminium. Tin, bismuth, silver, and gold were therefore weak or only slightly active. "Escaline" (metallic aluminium with glycerine) had a powerful action on the gastric secretion, and for this reason it was contra-indicated in cases of ulcer of the stomach, although it was recommended for that purpose. "Escaline" had no hæmostatic properties as experiments on animals had shown. It was decomposed in the presence of human blood. (This reaction was demonstrated).

Hr. Rumpel showed two patients with

CYSTIC DISEASE OF BONES.

1. The patient had been ill for two years. The disease began with pain in the right ankle, which resisted all the various kinds of treatment made use of. The talus was puffed, whilst the joint of the foot was free. A diagnosis was made of new growth in the talus. Röntgen illumination showed a cystic tumour. The operation undertaken for removing the talus confirmed the diagnosis. Microscopic examination revealed a round-celled sarcoma. The patient was now walking quite well.

2. A female with cystic tumour of the femur. The disease began a year and a half ago with pain in the left hip joint. All treatment was in vain. The patient came to the surgical clinic in the beginning of April. Examination showed that the hip joint was free, the disease being situated in the upper part of the femur, which was swollen and very painful. One had the sensation, on pressure, as if a "'pit" was made in the part. Röntgen illumination showed a solitary bone cyst. At the operation a cyst the size of an hen's egg was found in the upper part of the femur, this was cleared out, and no remnants of tumour were left in the cyst walls. The soft parts were united by suture, and healing took place by first intention.

Hr. Senator showed a case of

"MIKULICZ'S DISEASE."

The patient was a girl, æt. 6, her face was swollen and of a yellow colour. All the glands of the face were swollen and indurated—the lachrymal gland as well. There was also hard swelling of the eyelids, and slight exophthalmos from swelling of the retrobulbar tissues. The case was one of Mikulicz's disease. Moreover, all the lymph glands of the body were greatly swollen. Examination of the blood showed lymphatic leucæmia. To this collection of symptoms was superadded swelling of the periosteum of the flat bones of the skull, especially of the frontal bone; the ethmoid bones also appeared to be affected—one as chloroma or chlorolymphoma or chloromyeloma. There was here, therefore, a triad of rare diseases. The speaker was reminded of a case in which his views did not agree with those of Heubner; he was of opinion, however, that the autopsy showed that his view, that the case was a chloroma, was correct. Two other cases were then shown, one a case of acromegaly, with two rare complications—strabismus convergens and enlargement of the larynx; and the second a case of fibroneuromata.

Hr. Heubner observed in regard to Senator's case, that it was not a chloroma, but a lymphoma of the thymus with leucæmic new growth. At the autopsy there was nothing but leucæmic swelling on the periosteum, and there was no green colouration.

Hr. Marcuse said that he had shown a case of Mikulicz's disease before the Society two years ago, and he would like to report its further course. There was swelling of all the glands and extension of the cardiac dulness. Then great œdema came on, and death took place with ascites and cardiac weakness. The autopsy showed no leucæmia, and only immaterial changes were found in the blood. All the lymph glands, especially the bronchial, were enlarged, some to the size of the fist. According to this the case was one of pseudoleucæmia.

Hr. Senator reiterated that by Mikulicz's disease was understood enlargement of the salivary and lachrymal glands, and there were round-celled growths in the glands. The grey colouration of chloroma was "akzidentell," and was not present in leucæmia.

At the Medizinische Gesellschaft Hr. C. S. Engel gave an address on

REVERSION IN EMBRYONAL BLOOD FORMATION AND THE ORIGIN OF MALIGNANT TUMOURS.

He sketched briefly the development of blood in the human embryo, and concluded with saying that the marrow of bones was the place where the red blood corpuscle was formed, and where it remained all through life, with this distinction that youthful bone marrow was red, whilst that of adults was yellow. The red blood corpuscle also differed in their different stages; first, the only slightly differentiated macrocyst; later, the highly differentiated erythrocyst of the adult.

Regeneration of the blood might take place normoblastically and megaloblastically. The latter process was a reversion in the embryonic condition, with which an end-differentiation of the cell was associated—an atavistic process.

The end-differentiated cells could now develop without limit, without again taking on a distinct character, or they might again assume their specific character.

The same thing happened in malignant tumours, where an end-differentiation of the cells preceded the unlimited development.

He then discussed the question why did not the cells of the embryo grow into the maternal uterus, destroy this like a malignant tumour, and with it the maternal organism; he traced the parallels and enumerated the protective appliances of the maternal organism, and held it here to be not impossible that further inquiry should yield important disclosures for the successful treatment of malignant growths.

AUSTRIA.

Vienna, Sept. 15th, 1907.

STATIONARY PARALYSIS.

AT the Psychiatry Meeting, Rocke raised the question of Stationary Paralysis. Was there such—And was it curable? Under this term a nerve disease was recognised, which went on for years without much change to the onlooker; indeed, some question if paralysis exists. If any one takes the trouble to enquire at a mental institution he will often meet with a history like the following:—A patient is received with paralysis, which may go on for four or five years with very little change, but the patient suddenly dies. The *post-mortem* reveals no cause of paralysis, but on the other hand, the brain will indicate the presence of the syphilitic virus, arteriosclerosis of the cerebral vessels with signs of alcoholic degeneration and dementia præcox. Such cases only teach us how difficult it is to diagnose, and at the same time warn us in the management of large institutions to be careful of sudden deaths.

Alyheimer related the history of a similar case with supposed stationary paralysis. The patient was 32 years of age, and died suddenly. The microscope revealed a syphilitic condition, which undoubtedly caused the paralysis, which could not in the real sense of the word be "stationary."

Kraepelin thought such cases of paralysis were only transitory conditions in the progress of other diseases, and should be carefully observed; but with the serum and cerebro-spinal fluid tests the differential diagnosis and treatment should not be so difficult.

MENTAL MORAL WEAKNESS.

Gudden drew attention to the essential difference of opinion on this subject. Lombroso was convinced that property of the brain was the natural sequence of the mental organ returning to its original level as found in the savage, which is only translation of the animal disposition. On the other hand, Naecke opposes this view as impossible that such a disposition can be transferred from the animal to the human being, and attributes the condition to disease.

Forel has preached for years that the law of evolution is as true of the intellect as it is of the body.

Wasman teaches that a gulf between the animal and human intelligence exists which we cannot exactly fill in. We recognise the one side by intellect, the other by instinct. We may acknowledge the phylogenetic development of the human psyche from the lower animal, and the psyche of the cultured man from the savage; but the question still remains: Is this mental moral weakness similar in quality and character to the savage? Take the negro race of America. It is now established beyond doubt that we are not able by culture and education to raise the black race above that mental plane. Cases are reported of success in this direction, but these are only white-washing—the black never changes in nature.

Nothing will raise them to the higher ethics of self sacrifice, gratitude or truth; even repentance in the negro is unknown, or when it does appear, it is only hypocrisy. The capacity for learning is there, but the power of thinking in the abstract or reasoning from premises with a correct judgment are lamentably absent. We cannot compare the diseased brain of the white man with the healthy organ of the negro; there is no disturbance in the latter, no vision, fancies or imaginings that we have in the diseased brain. The brain of the negro was not first diseased then become sound, and no morbid process had ever entered into its composition—it was an inhibited virgin brain and would remain so by atavism. More importance must be placed on the race than the size of the brain, its coverings, central ganglia, and its peripheral connections.

Experience teaches that punishment by imprisonment or fines has no effect as a deterrent on the negro, but enforced work has some influence.

CONCURRENT ANTAGONISTIC BODIES.

Bresina has been experimenting with animals in the laboratory, and comes to the following conclusion—The animal treated with different blood or erythrocites forms a power of antagonism against all in a greater ratio than the control animal with only one sort of blood, or, in other words, a reciprocal limitation of the antigene is absent. The presence of this antagonistic body in the former does not prevent the formation of other new bodies. The presence or absence of a normal hæmolysin in a serum does not therefore prevent the formation of an immune hæmolysin.

The injection of one sort of blood into a guinea-pig increases the lytic power of other sorts of blood that may follow. We have therefore not only agglutinating bodies formed, but also hæmolytic antagonists and antigenes at the same time, the concurrence of the antagonistic bodies playing no active part whatever. Should prophylactic innoculation be required, one or more make little difference in the result.

SPONTANEOUS BIGEMINA.

Vanysek, at his clinic, exhibited a young man, æt. 28, who when 24 developed sexual neurasthenia, followed by this inversion of rhythm of the heart's action, coming under the generic term of "Allorhythmia," which includes bigemina and arhythmia, the former inverting the beats, the latter an irregularity of movement. Since his illness paroxysms of this bigemina come on with a painful burning sensation over the cardiac region with ice-cold extremities, which he considered was produced by an extra-systole movement which Hering termed an "unabridged bigemina." There was no organic change or other morbid condition present to account for the disorder. There were chronic contractions of the sphincter iridis, making it difficult to examine the fundus exalted vaso motor reflex, isolated bending of the phalanges of the third fingers, with prominent spasms of the platysma myoides present. A strange feature of this case was that the patient could now spontaneously call forth these phenomena and check them at will by different movements, positions, or holding the breath.

Cerebro-Spinal Therapeutics.

Radman has been experimenting with animals on this disputed question of injecting or inoculating under the skin against the original idea of injecting into the dural sac. With cultures of the epidemic cerebro-spinal virus he was unable to produce the disease in animals but when injected into the dura sac the disease was virulent. He therefore concludes that cutaneous or subcutaneous tissue is unsuitable or adverse to the growth of the meningeal cocci and therefore no local or constitutional effects would result from vaccination. Injecting the fluid drawn from the same animal was equally worthless as far as cure was concerned, as it had no effect in alleviating any of the symptoms.

HUNGARY.

Budapest, Sept. 15th, 1907.

At the recent meeting of the Budapest Inter-hospital Association, Dr. Schmidt read an interesting paper on the

Value of Tuberculin Reaction.

He tried to prove that the tuberculin reaction is not infallible in the diagnosis of tuberculosis. His technique is as follows: After absence of fever has been assured, for several days by four hourly measurements, one milligramme of tuberculin in fresh solution is injected, then, after four to five days, five times this amount. In eight cases with positive reaction, tuberculosis was found at autopsy in only five, in three carcinomata of œsophagus and stomach were the sole lesions. In one there was no reaction, yet evident tuberculosis. Despite such small doses and great care in injecting, serious accidents may occur and a latent process may suddenly become active and even lead to a rapidly fatal issue. This happened to Dr. Schmidt in three cases—one of leprosy, combined with tuberculosis, one of incipient apical tuberculosis, and one of affection of the serous membranes. A source of error is to be found in hysterical patients, they sometimes: react after tuberculin injections and even after injections of plain water.

Dr. Feleki spoke of a case of

Henoch's Purpura.

He referred to a patient who had been admitted to the surgical side of the hospital with pain, tenderness and a leucosytosis. She was prepared for operation, with the idea that there was some acute abdominal trouble, but a bilateral purpura was discovered accidentally, a diagnosis of Henoch's purpura made, no operation done, and patient recovered. He referred to another case of his own, in which there was recurrent abdominal pain closely resembling attacks of gall-stone or kidney colic. The appearance of a marked erythema, however, made it clear that the case was one of a visceral crisis accompanying a skin lesion. He said that he had also seen the condition after the administration of the anti-toxin of diphtheria. In this patient a violent erythematous urticaria appeared over the whole body eight days after treatment. With it there was œdema in both eyelids, a slight arthritis. The symptoms promptly disappeared.

Dr. Barta read a paper on

Immediate Repair of Laceration of the Perineum.

He pointed out the importance of closing up even small tears of the perineum, so as not to leave raw surfaces for septic absorption. It was important to close large tears so as to retain the function of the pelvic muscles. The best time to put in these stitches was just before the head pressed on the perineum, while the patient was næsthetised and before the parts had lost their relative positions. With the left finger in the vagina, and the thumb in the rectum, a large perineum needle on a handle was passed just under the vagina, threaded with silkworm gut; the two or three stitches hung loosely in a Pean forceps, until the placenta had been delivered, when they were quickly tied, bringing the parts exactly together as they were before the tear.

Dr. Révész related his experiences regarding

Pulmonary Embolism.

This condition and its evil associate, femoral thrombosis, are as inexplicable as they are to be dreaded. Neither has any bearing on wound infection, in fact, it is well known that each is more apt to occur in the course of an uneventful convalescence than otherwise. Have phlebitis and pulmonic embolism a common origin? Each, so far as can be determined at any rate, is aseptic, and each occurs typically after the most successful operations. It is possible that changes in the blood occur which are not evidenced by known methods of examining this tissue. But why should thrombosis of the left femoral occur so frequently after operations on the right side. That the two conditions are associated with each other and with some form of anæmia is to be suspected at least from the frequency of their occurrence in patients who have suffered prolonged hæmorrhage.

Care of the City Poor.

The Budapest Association for Improving the Condition of the Poor are doing a vast amount of good, and while they are necessarily expending a large amount of money it is more than saved when it is considered that the people whom this association is helping would fall to the care of the city hospitals. The following figures show the extent of the work:—37 mother and 81 children were taken recently to their summer home on the coast of the Adriatic Sea at a total expense of about £50. The association hopes to send several such groups from the crowded tenement districts. Twenty-five shillings will send a mother and baby to the seashore for a week.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

Belfast District Lunatic Asylum.—The annual report of this asylum, just issued, is as usual a most interesting document, for Dr. William Graham supplements the official statistics with his own comments, often of a most original nature. The daily average number of cases under treatment was 1,108, and the total admissions 241. As regards causation of mental disease, Dr. Graham says that heredity is given as the cause in 62 of the admissions, but this is only the way in which the insanity is transmitted, and does not explain the original cause. Seventeen cases were attributed to alcohol, but here again the statistics are not satisfactory, and Dr. Graham evidently agrees with the opinion, which he quotes, that about 50 per cent. of the cases are due to syphilis and alcohol. The recently published views of the Inspectors of Lunatics that the Irish race is particularly prone to mental disease drew some vigorously expressed opinions from Dr. Graham. "If the nation is in danger of becoming a nation of lunatics, it does not much matter who governs us, or how much land the peasant possesses," and such observations as the Inspectors have made call for the most serious attention. He thinks that there are no doubt preventable causes at work both in Ireland and America to bring about this degeneracy in the nervous system among the Irish in both countries, and that the race is not specially "contaminated with the virus of insanity." The Russian and Hungarian peasant, emigrating under much the same circumstances, does not show the same liability to insanity as do the Irish, and Dr. Graham suggests that this may be due to the greater mental activity of the last; his brightness of intellect, and keen susceptibility to joy and sorrow render him more liable to mental breakdown in the new conditions of life—the crowded tenements of big cities, and the keen competition for a livelihood. The ratio of recoveries to the total number of admissions was 28.6. Of the deaths, 15 were due to general paralysis of the insane, a disease a few years ago almost unknown in Ulster. As regards finance, it appears that after deducting receipts from paying patients and other sources the net capitation cost is £21 1s. 8d. per annum and the amount payable out of the general purposes fund of the city is £11 3s. 6d. for each patient chargeable to the ratepayers.

LETTER TO THE EDITOR.

AN APPEAL TO THE MEDICAL PROFESSION.

To the Editor of The Medical Press and Circular.

Sir,—Allow me to bring under your notice a distressing case that has occurred in this neighbourhood. In January last, Dr. J. P. Maguire was seized with sudden and severe illness, and succumbed to an attack of acute Bright's disease. He left a widow and a little boy, aged 10 years, quite destitute, and I am trying to get together enough money to pay for the widow's training as a midwifery nurse. The little boy we have a prospect of getting settled in a school near Dublin.

So far I have only applied locally, but the response has been so feeble I am forced to appeal to a larger public, the charitable members of the profession.

The following have already generously subscribed:

	£	s.	d.
Dr. Haurahan, Hollymount	2	2	0
Dr. Temple, Cong	1	1	0
Dr. F. Golding, Headford	1	1	0
Dr. A. Gill, Westport	1	1	0
Dr. Corcoran, Ballinrobe	1	1	0
Dr. Macaulay, Ballina	1	0	0
Dr. Costello, Tuam	1	0	0
Dr. McNulty, Killala	1	0	0
Surgeon-Gen. Joynt, Dublin	0	10	0
Dr. Hegarty, Clonbur	0	10	0
Dr. Mahon, Ballinrobe	3	3	0
Donation from Royal Medical Benevolent Fund	15	0	0
	£28	9	0

Of this sum, £4 has been disbursed for pressing necessities, leaving £24 9s. in hand. If this could be brought up to £50, it would enable us to place the widow in a position to support herself.

I am, Sir, yours truly,
R. B. Mahon.

Ballinrobe, Co. Mayo, Sept. 14th, 1907.

[We shall be very glad to receive subscriptions for this most deserving object, and we appeal to our readers for their aid. All subscriptions received will be acknowledged in the journal and forwarded to Dr. Mahon.—Ed., M.P. & C.)

OBITUARY.

CHARLES MACKINNON,, CLARK, M.D.Brux., M.R.C.S., L.R.C.P.

We regret to record the death of Dr. Charles Mackinnon Clark, which occurred at his residence, Rose Hill, Dorking, on September 4th. Dr. Clark, who was only 42 years of age, was taken ill soon after he began his summer holiday at Zermatt, in the early part of June, and is supposed to have contracted ptomaine poisoning. In the beginning of August he left for Cornwall, and at first he seemed to improve, but gradually he became worse again, and was brought home in a serious condition. He never regained his strength, and passed away exactly a week after his return home. Dr. Mackinnon Clark was very popular among all classes, and his death has caused much sorrow in the town, while sympathy is especially felt for his widow and their child. Educated at St. George's Hospital, Dr. M. Clark, after qualification, joined his father in his extensive practice at Dorking, and since his father's death he continued the practice alone. He was one of the honorary medical officers of the Dorking Cottage Hospital, and medical officer to the Dorking Oddfellows.

THOMAS LOGAN, M.D.Aber., AND F.P.S.Glasg.

We note with regret that the death took place on September 4th, of Dr. Thomas Logan, in his 67th year. Dr. Logan was educated for the medical profession at Glasgow and Aberdeen Universities, and on the completion of his medical course he was appointed superintendent of the Paisley Infirmary. He subsequently went into general practice in Dumfriesshire, where he was Medical Officer for the long period of twenty years for the parishes of Penpont, Keir, and Tynron. He then left that place to commence practice in Wibsey, near Bradford. At Wibsey, he was first partner with the late Dr. Warburton, and on his death succeeded to the practice as well as to all the public appointments connected with it. He was Medical Officer of Health for North Brierley; indeed, in the Wibsey district he was in public and private service there for twenty-five years. On his retirement he was entertained to a public banquet in the Midland Hotel at Bradford by lay and medical representatives of the city, the function being attended by many from north and south. Dr. Logan came to Harrogate about two years ago. He had for a long time been diligently engaged in scientific study, and it is hoped that the fruit of his labours in this direction will eventually be made public.

STUART NAIRNE, F.R.C.S.Ed., F.F.P.S.Glas.

We regret to announce the death of Dr. Stuart Nairne on September 8th, at his residence in Renfrew Street, Glasgow. A native of the burgh of Irvine, Dr. Nairne was educated at St. Paul's Parish School, at the Normal Training College in Dundas Vale, from which he passed to the University, where he took high honours and secured a £50 bursary in the chemistry class. At the close of his medical curriculum, Dr. Nairne began practice in Glasgow, his special interest lying in surgery. He conducted for some time a ladies' class for gynæcology in the Western Medical School, which was largely attended. Impressed with the great amount of suffering among women, he was the moving spirit in the foundation of the Samaritan Hospital for the free medical and surgical treatment of women. In association with Dr. George Halkett, the late Mr. Thomas Jenkins, and Mr. Thomas MacQuaker, the present secretary and treasurer of the hospital, and several other gentlemen, he formed the project in December, 1885, and on January 4th, 1886, the hospital was inaugurated by Lord Blythswood. Dr. Nairn was the first surgeon of the hospital and Dr. Halkett its first physician. He took a great interest in the recent extension of the institution, and he was present at the opening of the new section by Lady Blythswood in April last. On his retirement he was the recipient of a public testimonial, consisting of a cheque for about £300, a study chair, and of silver plate for Mrs. Nairne. Dr. Nairne was an occasional contributor to the medical journals, and in 1883 he published several medical works. Of the Glasgow Obstetrical and Gynæcological Society Dr. Nairne was the first honorary secterary. Dr. Nairne is survived by his wife, one son, and three daughters.

SPECIAL ARTICLE.

VITAL STATISTICS OF IRELAND.

The "Annual Report of the Registrar-General for Ireland" for the year 1906 contains little that can cause comfort even to the most optimistic. With a stationary death and marriage-rate, an increased emigration rate, and a progressively decreasing population, it is difficult to deduce any sign of prosperity from the Registrar-General's figures.

The number of marriages registered in Ireland during the year 1906 was 22,662; the number of births, 103,536; and the number of deaths, 74,427. The marriage-rate was 5.16 per 1,000 of the estimated population, showing a decrease of 0.10 as compared with that for the year 1905, but is 0.08 above the average rate for the ten years 1896-1905; the birth-rate was 23.6 per 1,000 of the estimated population, showing an increase of 0.2 as compared with that for the preceding year, and is 0.4 above the average rate for the ten years 1896-1905; and the death rate (17.0 per 1,000) is 0.1 under the rate for the preceding year, and 0.9 under the average rate for the ten years 1896-1905. The natural increase of population, or excess of births over deaths, was 29,109; the loss by emigration amounted to 35,344; it would appear, therefore, that there was a decrease of 6,235 in the population during the year, but against this decrease there is a set-off in immigration, of which there is no official record. Its effect is probably very slight.

The Registrar-General expresses regret that there is an increasing majority of instances in which the ages of the persons married are not stated, and in which the only information of age given is the word "minor" or the words "full age."

Of 22,662 men married during the year, 311, or 1.37 per cent., were minors; and of the women married 1,096, or 4.84 per cent., were under age. Of those married under age in 1906 the highest proportion of husbands (1.71 per cent.) was in the province of Leinster, and of wives (5.89 per cent.) in the province of Ulster. The percentage of persons married in Ireland, who were under age, is very far below the corresponding percentages in England and Scotland.

The highest marriage-rate for county, or county borough areas (7.9 per 1,000 of the population) was in the county borough of Dublin; and the lowest 3.1 in each of the counties of Clare and Mayo. Between these extremes the most favourable rates were 7.8 for the county borough of Belfast, 5.7 for the county of Dublin, and 5.6 for the county and county borough of Londonderry, and the least so 3.4 for the county of Galway, 3.4 for the county of Roscommon, and 3.8 for the county of Meath.

The 103,536 children whose births were registered in Ireland during the year 1906, include 100,845, or 97.4 per cent. who were legitimate, and 2,691, or 2.6 per cent. who were illegitimate, being equal to the corresponding average percentages for the preceding 10 years. These results compare favourably with the returns for most other countries.

The proportion of illegitimate children is as usual highest in Ulster, and lowest in Connaught, the rates for the four provinces being:—Ulster, 3.5 per cent.; Leinster, 2.7; Munster, 2.2; Connaught, 0.7.

Taking the county or county borough areas, the four highest birth-rates were 33.0 for Dublin county borough; 31.2 for Belfast county borough; 24.4 for county Kildare; and 24.1 for county Antrim. The four lowest rates were—18.3 for county Cavan; 18.4 for Queen's county; 18.7 for county Roscommon; and 19.0 for county Longford.

During the year 1906 the number of deaths registered in Ireland was 74,427, equivalent to 1 in 59, or 17.0 per 1,000 of the population estimated to the middle of the year. The deaths of males amounted to 37,131, and those of females to 37,296, the rate per 1,000 males and 1,000 females, respectively, being 17.1 and 16.9.

The five county or county borough areas having the lowest mortality rates per 1,000 of the population were:—County Mayo, 11.7; county Leitrim, 12.0; county Galway, 12.8; county Kerry, 12.9; and county Roscommon, 13.1. The highest rates are as follows:—Dublin county borough, 25.0; Belfast county borough, 20.6; county Armagh, 19.0; county Monaghan, 18.9; and county Down, 18.1.

More than 14 per cent. of the deaths registered took place in workhouses or workhouse hospitals.

As usual Mr. Matheson represents by a diagram the principal causes of death operative during the year. Tuberculosis again presents the highest column with 11,756 deaths, old age coming next with 8,409. In discussing the incidence of zymotic diseases the Registrar-General comments on the great decline in the mortality from enteric fever. The number of deaths from this disease was only 394, as against an annual average of 755 for the 10 years 1896-1905. In 1898, no fewer than 1,284 of the inhabitants of Ireland died of enteric fever. Of the deaths in 1906, 97 were registered in Belfast county borough, and 48 in Dublin county borough.

The deaths from typhus have during the past two years shown a tendency to increase in number. They declined from 128 in 1900 to 53 in 1904, rose in 1905 to 68, and last year to 86.

There was in 1906 a high mortality from diarrhœal diseases, the deaths registered mounting to 1,675. Of these, 379 occurred in Belfast, and 359 in Dublin.

There has been no death from rabies since 1898.

To the subject of tubercular diseases the Registrar-General devotes careful attention, and those interested in the campaign against tuberculosis cannot fail to be grateful to him for his graphic representation of facts and his strong comments thereon. He attempts to draw the special attention of the Lord Lieutenant to the matter, and goes on:—

"In introducing this subject, I may state that the fall of the mortality rate for tuberculous disease in England and Wales during the 42 years from 1864 to 1905, as may be seen in the diagram facing this page, is a proof that the disease is at least capable of being successfully combated, and for the purposes of the militant sanitarian may be looked upon as a preventable disease. I cannot, your Excellency, say that it is a matter of much congratulation that the high death rate of 2.9 per 1,000 in the year 1904 for all forms of tuberculous disease has declined to 2.7 per 1,000 in the years 1905 and 1906. When I come to enumerate the figures which I have compiled, I find that there were 11,756 victims, inhabitants of Ireland; in other words, out of a total of 74,427 deaths registered in Ireland during the year 1906, no less than 11,756, or 15.8 per cent., were sacrificed to a disease which is in a great degree preventable. It is a difficult matter for me to dissociate myself from responsibility in such appalling circumstances, and I cannot feel that my duty terminates in merely collecting and classifying these most depressing statistics. Year after year these facts are published, and although the members of the medical profession are strenuous in trying to awaken the public mind to a state of affairs that can only be considered as destructive to the community, yet, comparatively speaking, our countrymen are not alive to the dangers which threaten them. Our people have shown that they are not slow to appreciate the benefits of vaccination as a protection from small-pox, and when they are thoroughly awakened as to the infectious character of tuberculous disease they will be the first themselves to aid in its prevention."

The diagram comparing the condition of affairs in Ireland with that in England and Scotland shows that, while in England the rate has declined from 3.3 per 1,000 in 1864 to 1.6 per 1,000 in 1905, and in Scotland from 3.6 per 1,000 in 1864 to 2.1 per 1,000 in 1905, it has risen in Ireland from 2.4 per 1,000 in 1864, to 2.9 in 1904 and to 2.7 per 1,000 in 1905 and 1906.

The number of deaths due to phthisis was 8,933, and it is noticeable that the highest incidence was between the ages of 25 and 35.

Mr. Matheson mentions that "the large proportion of uncertified deaths in Ireland (24.4 per cent. of all deaths registered) during the year 1906 is a matter of grave importance both from the public point of view, as well as from the point of view of the profession of medicine." But there is little doubt that the explanation lies in the fact stated by him that a custom prevails in many parts of the country of not seeking medical advice, especially for the aged and those suffering from chronic forms of disease. The large number of persons returned as dying of "old age" bears out this view. The total number of deaths from accident, homicide, and suicide which were recorded in the death registers of Ireland in the year 1906 was 1,875—by accident 1,685, by homicide 43, and by suicide 147 deaths. Of the total deaths attributed to accidental circumstances, 1,126 were of males and 559 were of females. With this number of deaths as the result of violence, we fail to understand why there is record of only 1,788 inquests.

Mr. Matheson furnishes fuller information on the subject of infant mortality than has been his custom heretofore. Two illustrative diagrams give respectively the comparative infant mortality curves of the three countries, and the effects of fourteen principal causes in producing infant mortality in Ireland. In addition, he furnishes a map showing the relative rates in the different unions throughout Ireland. In the rural districts there is, of course, a low rate of infant mortality, but in the town districts it is high. The rate for the 22 chief town districts is 135.02 per 1,000 children born, dying in the year. In the aggregate, however, the infant mortality rate of Ireland compares favourably with that of other countries. In England and Wales the infant mortality rate, which in 1864 was 153 per 1,000 births registered, was 133 in 1906; that in Scotland in 1864 the rate was 126, and in 1905 it was 116; while the infant mortality rate for Ireland in 1864 was 98 per 1,000 births registered, and in the years 1904, 1905, and 1906 the rates were 100, 95 and 93 respectively.

The general arrangement of Mr. Matheson's report is, as usual, excellent, and gratitude is due to him, as well as to Dr. Ninian Falkiner, Medical Superintendent of Statistics, for the interesting manner in which information is given to the public.

REVIEWS OF BOOKS.

THE NURSLING. (a)

Professor Budin's last work has a peculiar fascination in that it gathers up the threads of a lifetime's toil and places on record the thoughts and opinions of an enthusiast who made the subject of which he treats peculiarly his own. It may be owing to France's need for population that infant-rearing has been studied so carefully in that country, but certain it is that we have as yet very little to show in Great Britain to match in interest or importance the organisation that is springing up in that country for the care and protection of the infant. These practical results are the outcome of the efforts of the school of obstetrics of which Pinard and Budin were the foremost teachers, and in the placing of infant-culture on a scientific basis the last-named must ever take the credit due to the pioneer. What Budin's difficulties must have been we are not told, but we can imagine him triumphing over them all with that genial optimism and delighted confidence which are so strongly in evidence in this book. It is, indeed, just the sort of book it takes a Frenchman to write—original, clever, logical, even brilliant, so that the reader puts it down with a sigh at his own denseness for not knowing how easy it is after all to rear premature and weakly children. But on second thoughts he begins to doubt whether it is so easy, and to wonder whether the genial professor does not see everything through *couleur de rose* spectacles. Indeed, we have here in this book something more than a mere professor; the author is half Santa Claus, half fairy godmother. Is anything wrong with the baby? In pain? Sick? So, a few kind remarks, a gentle turn of the wrist, and lo! it is well. But for all that let Professor Budin be optimistic. It is the optimist who conquers the world, and this work of his has gone a long way towards systematising and placing on sure ground the rearing of the babies of the State, and if we do not agree with him in his estimate of sterilised milk, and in all his other opinions, we can truthfully say that this is the most important work on the subject that has yet been published, and that if France is ever again to have a *grande armée* whether of war or of industry, she will owe it more to Budin than to the doctrinaires who prate in their armchairs of falling birth-rates.

A TREATISE ON ORTHOPÆDIC SURGERY. (a)

In this "Treatise on Orthopædic Surgery," the author, Dr. Whitman, has succeeded in presenting the subject in a most interesting and instructive form. The general appreciation of this fact is no doubt the reason why this work has now attained its third edition.

In dealing with disabilities and deformities one is led by the author to the rational method of their treatment, by a study of the particular affection from an ætiological and mechanical point of view. For instance, in the chapter on Weak or Flat Foot, where, perhaps, we can form the best idea of the way in which the subject is treated, we find paragraphs under the following headings: General description of the foot and of its functions, the arches, the foot as a passive support, in activity—Improper postures—Movements—Function of the muscles—Strength of the muscles (with tables)—The foot as a mechanism—The weak foot or so-called flat foot—Description—Anatomy—Pathology — Etiology — Statistics — Symptoms—Diagnosis—Varieties—Weak foot in children—Exceptional forms—Treatment — Preventive — Exercises—Support—Construction of brace—The rigid weak foot—Forcible correction of deformity—Subsequent treatment—Adjuncts in treatment—Operative treatment. In the work generally, operative treatment (by the knife) is briefly indicated, and, as a rule, not given in detail. We may say that each section is lucid, concise, and to the purpose, making the work a useful acquisition to the student, the general practitioner and worker in this special branch of surgery.

It is a difficult matter in a review to touch on all the excellent qualities that might be alluded to in this work. Considerable attention has been paid to the methods of examining, measuring, and recording deformities. Also careful descriptions are given of exercises, manipulations, and apparatus used in their treatment—a subject that is not always dealt with in so thorough a manner as it is here. But in this connection, more might certainly have been said with advantage on the manipulative treatment of congenital club foot.

In conclusion, this Orthopædic Surgery contains 554 well chosen illustrations, mostly reproductions of photographs, and some skiagraphs. These numerous illustrations, though not an essential part of the work, as it is in some of the more recent medical text-books, especially from America, add very materially to the value and utility of the book.

ADAMSON ON SKIN DISEASES. (b)

As a "practical guide to the clinical study and treatment of skin affections in children" Dr. Adamson has produced a book "based very largely" upon his own personal experience, and, in common with other works of a like character, it suffers from a certain want of balance. We must confess that we expected to find it brimming over with descriptions of cutaneous lesions and manifestations such as are only found in childhood, but, although some of the disorders treated of are dealt with from the point of view as they appear at this age, sufficient stress is not laid upon the clinical differences between skin affections of children and adults. The best part of the book is that dealing with ringworm of the scalp and its treatment by the X-rays. The chapter on eczema is also good, the author taking the view that "an affection which is primarily microbic is not eczema." He has retained the not altogether satisfactory term, "tuberculous eczema," while admitting that the type thereunder described has no relation, in his opinion, to tuberculosis. It is rightly stated that the key-note of successful treatment in infantile eczema is protection from irritation, and that unless this be adequately secured the best remedies will fail in their action. The supposed danger of curing an eczema in childhood rapidly is not treated very seriously, and no caution is specially advocated against employing powerful or toxic remedies over large eczematous areas. Only two lines are devoted to caterpillar-rashes which, if not very important, have attracted considerable attention both in this country and also in America. The harvest-bug is not mentioned, though its lesions are common enough among children who romp in cornfields and play among hayricks in summer. The photographic illustrations are excellent, and there is a useful list of formulæ appended. The index might with advantage have been much fuller.

(a) "The Nursling: the Feeding and Hygiene of Premature and Full-term Infants." By Pierre Budin, Professor of Obstetrics, University of Paris. Authorised Translation by William Maloney, M.B., Ch.B. With an Introduction by Sir Alexander R. Simpson, M.D., LL.D., D.Sc. 111 diagrams in colour. London: The Caxton Publishing Co. 1907.

(a) "A Treatise on Orthopædic Surgery." By Royal Whitman, M.D., Clinical Lecturer and Instructor in Orthopædic Surgery in the College of Physicians and Surgeons of Columbia University, New York, &c. Illustrated with 554 engravings. Pp. xii. and 871. London: Henry Kimpton. 1907.

(b) "Skin Affections in Childhood." By H. G. Adamson, M.D., M.R.C.P., Physician for Diseases of the Skin, Paddington Green Children's Hospital, and the North-Eastern Hospital for Children. Oxford: Henry Frowde. London: Hodder and Stoughton. Pp. xvi. and 287. Illustrated. Price 5s. net.

TICS AND THEIR TREATMENT. (*a*)

THE translator has conferred a service on his colleagues by publishing this important work. The authors favour the distinction, originally observed by Willis, between continuous, permanent tonic convulsions, and intermittent, momentary clonic movements. They regard the use of the epithet "convulsive" as superfluous, and prefer to employ the term "tic" by itself, save in such cases as it may be found absolutely necessary to indicate the precise nature of the muscular contraction. The pathogenesis of tic is discussed in the third chapter. In this connection, a very careful distinction is drawn between the two terms "tic" and "spasm," which are so apt to be used indifferently as if they implied the same condition. A tic is a co-ordinated, systematised, and purposive act. It results from voluntary repetition of the same movement by the patient; but mere repetition is not sufficient to evolve a tic in every case. Psychical predisposition is absolutely essential in the form of volitional enfeeblement, and the authors lay considerable stress on the important bearing of mental insufficiency.

The different tics are arranged and discussed under separate headings, such as facial, auditory, vision and arm tics. Numerous cases are given in illustration of these varieties. The treatment of tics naturally comes in for a considerable share of attention. To neglect them or to consider them incurable is entirely unwarranted. Drugs are of little value. Diet and general hygiene must be attended to, while hydrotherapy is always of service. Massage ought to be given a trial; but the use of mechanical apparatus in order to avert muscular insufficiency is deprecated, as is also electricity in all its forms. Hypnotic suggestion is very useful in some cases. Re-education is the only really valuable form of treatment, and the writers detail the exercises which the patient should in every case be made to carry out. He must be made to perform certain slow, regular, and accurate movements limited to the muscles of the area involved. These exercises must not be too prolonged. In addition, the patient should be required to remain absolutely motionless for a few seconds at a time. Other additional measures such as rest in bed and isolation are not generally commendable. The translator has done his work well, and the book has been excellently turned out by the publisher.

GENERAL SURGERY. (*b*)

THIS ambitious attempt to summarise all recent contributions of importance in the domain of surgery will doubltess be appreciated by "pure" surgeons. For the general practitioner its interest will probably not be so great. It at any rate serves the purpose of indicating the trend of present-day surgical procedure in the various departments. The task of selecting and summarising the material seems to have been very judiciously performed and, indeed, it would hardly be otherwise in the hands of such an accomplished and experienced editor as Mr. Murphy, whose fame is world-wide. There are a fair number of illustrations and diagrams in elucidation of the text.

We can quite believe, as stated by the editor, that the advance in the year's annual output of medical literature put his powers of discrimination each year to a severer test. Still, great advantage attached to such a summary if only because no ordinary person could possibly command so comprehensive a view of contemporaneous work and thought. One has only to look through the admirable synopsis of tuberculous literature to grasp the importance of the work here recorded. Text-books of the present day so rapidly go old in the sense of failing to remain abreast of the times that some such work as this is a well-nigh indispensable companion to the ordinary works of reference. Every practitioner wants, for instance, to post himself in the latest news or data concerning epidemic cerebro-spinal meningitis (which is dealt with here as distinct from "spotted fever."). Malta fever is fast becoming a subject of interest now that its existence in widely distant areas has been demonstrated, with the promise of a further spread.

It may be that the practitioner of the future will prefer this methodical way of adding to his store of information instead of taking it by tablespoonfuls in the medical journals, but after all the synopsis cannot replace that from which it draws its being, *e.g.*, contemporaneous medical literature.

MEDICAL NEWS IN BRIEF.

Award of Medals for Tropical Medicine Research.

THE Mary Kingsley medal, instituted by the Liverpool School of Tropical Medicine in memory of Miss Mary Kingsley, who died in 1900, has been presented to the gentlemen mentioned below for work of special research into tropical medicine:—

1. Colonel David Bruce, F.R.S., C.B., Royal Army Medical Corps, who in 1887 discovered the cause of Malta fever, and proved that that malady was produced by the milk of infected goats.
2. Professor Dr. Robert Koch, Nöbel Laureate, who ascertained the cause of cholera, and who has contributed much to the knowledge of tropical diseases, especially the discovery of the frequency of malarial infection in children.
3. Dr. A. Laveran, Pasteur Institute, Paris, and D.Sc., University of Liverpool, who in 1880 made the great discovery that malarial fever is caused by parasites in blood.
4. Sir Patrick Manson, F.R.S., K.C.M.G., London School of Tropical Medicine, who in 1878 discovered that one of the parasites of man belonging to the group of *Filaria* is carried by a kind of mosquito.
5. Dr. Basile Danilswsky, Professor of Physiology, University of Kharkoff, who discovered numerous parasites of blood in a large number of animals shortly after Laveran's discovery was made.
6. Dr. Charles Finlay, chief sanitary officer of Cuba, who in 1880 originated the theory that yellow fever is carried by mosquitoes.
7. Dr. Camirlo Golgi, Professor of Pathology, University of Pavia, who in 1887 made a complete study of the life cycle of parasites of malaria.
8. Colonel W. C. Gorgas, United States Army, who, as chief sanitary officer of Havana gave practical effect in 1902 to the discoveries of Finlay and of the American commission in connection with yellow fever, and succeeded in banishing the disease from the city.
9. Waldemar Mordecai W. Haffkine, C.I.E., who in 1893 discovered a method of inoculation beneficially used in India.

(*a*) "Tics and Their Treatment." By Henry Meige and E. Feindel. With a preface by Professor Brissaud. Translated and Edited with a Critical Appendix by S. A. K. Wilson, M.A., M.B., B.Sc., Resident Medical Officer, National Hospital for the Paralysed and Epileptic London: Sidney Appleton. 1907.

(*b*) "Practical Medicine Series." Edited by Gustavus P. Head, M.D., Professor of Laryngology and Rhinology at the Chicago Post-Graduate Medical School. Vol. II.—General Surgery. Edited by John B. Murphy, A.M., M.D., LL.D., Professor of Surgery in Rush Medical College. Series 1906. Chicago: The Year Book Publishers Glasgow: Gillies. Vols. I. and VI.—"General Medicine." Edited by Frank Billings M.S., M.D., Dean of the Faculty of Rush Medical College, and J. H. Salisbury, A.M., M.D., Professor of Medicine, Chicago Clinical School.

10. Dr. Arthur Loos, Professor of Parasitology, School of Medicine, Cairo, for work in connection with parasitology.

11. Dr. Theobald Smith, Professor of Comparative Pathology, Harvard University, who in 1893 discovered a new kind of blood parasite in the so-called Texas cattle-fever.

Yet Another Medical Manifesto.

Miss May Yates, hon. secretary of the Bread and Food Reform League, sends us a copy of a manifesto on the subject of food which has been signed by members of the medical profession and scientific societies. In this they say:—

"We desire to endorse the opinion expressed in the report of the Inter-Departmental Committee on Physical Deterioration that insufficient and improper food is a prominent factor in the causes to which degenerative tendencies might be ascribed, and that it also tends to produce a craving for drink.

"As the report shows that there is a very large amount of ignorance about the right choice and proper preparation of food, and as much distress would be lessened by a knowledge of foods which nourish completely at the least cost, we venture to urge the Lord Mayors and Mayors of London and of other cities and towns, all municipal authorities, societies, and individuals interested in ameliorating the condition of the people to direct attention to this important subject.

"Without advocating any special system of diet, we urge teaching the economic and nutritive value of much-neglected staple foods such as oatmeal, wheatmeal, barley, rice, maize, peas, beans, lentils, nuts, fresh and dried fruits, green and root vegetables, as their more general use would promote the health of all classes of society."

The manifesto is signed by, among others, Sir James Crichton-Browne, A.R.S., Sir Lauder Brunton, F.R.S., Dr. John Beddoe, F.R.S., Mr. Edward Berdoe, Sir William Crookes, F.R.S., Mr. A. D. Fripp, K.C.V.O., C.B., Mr. A. Pearce Gould, Mr. George Henslow, Dr. Robert Hutchinson, Dr. Robert Miller, Dr. W. R. Smith, Mr. W. B Tegetmeier, F.L.S., Dr. Sims Woodhead, and Sir Samuel Wilks, Bart., F.R.S.

Signatures in support should be sent to Miss Yates at 42a, Bloomsbury Square, London, W.C.

Infantile Mortality Congress.

The second international congress of authorities and societies interested in the milk supply and the protection of children against disease has been sitting in Brussels. Fourteen Continental and other Governments have sent official delegates. The British Government sent no official representatives, but both Australia and Canada did so. England was, however, represented informally by the following ladies and gentlemen: Drs. MacCleary, Taylor, and Liell, Miss Marion Fitzgerald, Mrs. L. J. Greenwood, Councillor W. Fleming Anderson, Dr. A. K. Chalmers, Alderman Broadbent and Dr. S. G. Moore, Dr. James Niven and Miss M. G. Taylor, Councillor Dr. Cullen, Dr. J. Milson Rhodes, Miss Zannetti, Dr. MacIntyre, Dr. Sydney Davies, representing the Associated National Conference of England on Infantile Mortality. Dr. L. Coit represented the American Association for the Control of the Milk Supply, and other kindred societies of the United States. A feature of the congress consisted in the practical demonstrations held at the Arts and Crafts Exhibition, now in progress at the Cinquantenaire, of the Pasteurisation of milk according to the method introduced by Mr. Nathan Straus in New York. The system of Mr. Straus is best described in a paper distributed at the congress.

London Consumption Conference.

A conference of representatives of metropolitan, city, and borough councils was lately held at the instance of the Paddington Council, at the Town Hall, to consider the best methods of preventing pulmonary tuberculosis, and various resolutions, including one in favour of compulsory notification, were adopted. These were sent to the President of the Local Government Board with a request that he would receive a deputation from the conference. Mr. Burns replied that "The subject (prevention of consumption) has received the serious attention of the Board, and a report on the matter is being prepared in their medical department, which they hope will shortly be issued. In the meantime, it does not appear to the President to be necessary that he should trouble the deputation to attend, but he will be prepared to consider any further statement which the councils may wish to submit to him in writing." Mr. A. W. J. Russell, Town Clerk of Paddington, honorary secretary of the conference, has, on its behalf, again asked Mr. Burns to receive a deputation. Sir G. Fardell and Mr. L. G. C. Money, the Members of Parliament for Paddington, have been requested to co-operate in securing a revision of the President's decision.

The Proposed "Tuberculosis Exhibition" in Dublin.

A meeting of the Consultative Committee of the Tuberculosis Exhibition, to be held under the auspices of the Women's National Health Association of Ireland at the Home Industries Section of the Exhibition, Dublin, in October next, was held recently in the Leinster House, Kildare Street.

Her Excellency the Countess of Aberdeen, President of the Association, occupied the chair, and opened the proceedings with a short speech, in which she detailed the objects of the Exhibition. Short descriptions were then given by the organisers of the different sections of the nature of their sections. Amongst the speakers were Professor McWeeney, Dr. Lily Baker, Dr. A. Boyd and Dr. W. J. Thompson. Sir Henry Swanzy, president of the Royal College of Surgeons then proposed a resolution approving of the steps taken by the Executive Committee with the object of forming a representative and instructive collection of objects illustrating in a popular manner the subject of tuberculosis and its prevention, and pledging themselves to do all in their power to make the forthcoming Tuberculosis Exhibition a success. This was adopted, and Dr. W. Calwell, Belfast, representing the Ulster Medical Society, moved a resolution commending the Tuberculosis Exhibition to the support of Irish public bodies and philanthropic organisations, and urging that steps should be taken to induce visitors to inspect it. This was carried unanimously, and after a vote of thanks to her Excellency for presiding the meeting ended.

Royal College of Surgeons in Ireland.

The second post-graduate course at the Royal College of Surgeons in Ireland will commence on September 23rd, and continue until October 15th. As almost the entire clinical material in Dublin will be available for purposes of instruction, the course should prove to be of the greatest value to medical men who desire to freshen up their knowledge and to keep abreast of the times.

We have received the Annual Illustrated Guide of the London and South-Western Railway (price 1d.), and we can cordially recommend it to the notice of those thinking of spending a holiday in the delightful country served by that line. The Guide is exceedingly well printed, illustrated, and got up, and it furnishes a large amount of useful information about the chief towns in the South-West of England. Nor is the Continent forgotten, and prospective tourists will find helpful descriptions of Paris and the Riviera to aid and guide them. Altogether it is quite a "monster" pennyworth.

Between 20 and 30 persons at Tollesbury and others at Wigborough, Peldon, Layer, Birch, and Salcot, have developed illness after eating brawn. Among the sufferers is the Rev. F. E. Crate, curate-in-charge at Salcot, and his family. Dr. Thresh is making investigations into the cause of the malady.

The Committee of the National Association for the Establishment and Maintenance of Sanatoria for Workers Suffering from Tuberculosis are about to open the second half of their main building at Benenden, Kent, which will accommodate 68 patients.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

The Transvesical Operation for the Relief of Prostatism.—C. Bowers, in a paper (*American Medicine*, July) on the relief of prostatism in the aged male, calls attention to the fact that a number of old men have enlarged prostates—some 60 per cent.—but of these not more than some 15 per cent. suffer from prostatism; on the other hand, many people suffer from prostatism whose prostates are not enlarged, the condition in these cases being caused by a contracture at the neck of the bladder. This may give rise to the same symptoms as an enlarged prostate does, and in many cases prostates are removed for such a condition, in which a much less severe operation would have sufficed to cure the patient. The writer does not think that it is possible to make a certain diagnosis of this contracted condition of the neck of the bladder without a digital examination, made through a suprapubic wound. The most noted changes associated with prostatism are—bulging of the posterior commisure, lengthening in, and distortion of the prostatic urethra, with some sclerosis of the prostate itself, and contracture of the neck of the bladder. This last condition being present in most cases and being the most important of the anatomical changes, is largely responsible for the symptoms of retention, congestion and inflammation at the neck of the bladder. The author is firmly convinced that the suprapubic method is far better for exploring the bladder than the perineal, and that more conservative and rational operations will yield better results, and lower the mortality of the former operation to equal or less than that of the perineal route. An exact diagnosis can in many cases only be made on the exposure of the vesical outlet. The suprapubic route is as rationally indicated for the relief of such obstructive lesions at the urinary outlet, as it is in the case of vesical calculus, the perineal operation offering only 30 per cent. of cures, with 1·07 per cent. mortality, and a 50 per cent. chance of having exchanged one urinary difficulty for another, and not infrequently a lesser for a greater one. The transvesical operation entirely relieves all who survive of their urinary troubles, if due to obstruction in or about the vesical outlet, except when carcinomatous in character. The controversy that is now going on relative to perineal and suprapubic prostatectomy is only a repetition of the one waged when lithotomy was undergoing its evolution. No one to-day cuts for stone in the male bladder per perineum. It is most essential that the profession should recognise, first, that prostatism is due to other causes than hypertrophy of the prostate gland, secondly, that the transvesical operation for prostatism has attained a sufficient degree of perfection to be recommended to this class of pitiable sufferers, with the assurance of cure if availed of before the inflammatory process has reached the kidney, and arrested its functional activity; thirdly, that such cases should not be submitted to catheterism in the future, as they have in the past, until it is hopeless to interfere surgically. G.

Fibrolysin in Abdominal Adhesions.—Emmerlich (*Allg. Med. Zeitung*, March) records the case of a man who had been severely injured in the upper part of the abdomen seven years before; this injury was followed by numerous adhesions forming about the stomach and intestines. A laparotomy was done, and these adhesions separated as well as possible, but in a short time the symptoms began again and finally the patient became worse than ever, the bowels only moving after strong doses of purgative medicine, and such medicine always caused intense pain before the bowels acted. Fifty injections of Merck's fibrolysin were given, into the subcutaneous tissue of the upper part of the abdominal wall, at first, but as this proved painful, they were afterwards given in the gluteal region, the patient's chief complaint being the strong taste of fibrolysin he felt in his mouth for some time after each injection. At the end of the course the bowels acted daily, without the aid of any aperients. Five months after the last injection, digestion was perfect, and defæcation quite painless and normal, so the cure is in all probability a permanent one. G.

Plumbism Following Bullet Wounds.—Professor Braatz (*Munch. Wed. Woch.*, May, 1907) relates the case of a beater, who received a charge of shot in both legs. This accident was followed in a few weeks by the onset of severe symptoms of plumbism, including neuralgia in the legs and both trigeminal nerves. There was such severe stomatitis, that the dental fangs were surrounded by pus, and twenty-four teeth were extracted. There were tremors in the fingers and tongue. In a very short time the patient lost nearly three stone in weight. The X-ray examination of the leg showed that there were only seven small pellets imbedded in the patient's leg. Only six other similar cases are recorded, and from them it is evident that the diagnosis is rendered unusually difficult by the apparent capriciousness with which plumbism occurs after such bullet wounds. Large bullets may remain in the body for years and give rise to no symptoms; in other cases a few grains of shot after lying latent for years, or within a week or two of the time they were imbedded in the patient, may give rise to a sudden attack of severe plumbism. Sometimes the onset is extremely insidious, one symptom after another appearing in the course of years. In doubtful cases the blood should be examined for basophile granules in the erythrocytes. G.

The Treatment of Chronic Constipation with Regulin.—(*Theapic d. Gegenwart*, May, 1907).—Meyers' results from the use of regulin (agar-agar plus a small amount of cascara) in the treatment of chronic constipation have been excellent, like those of most previous writers on the subject. Out of 71 cases 62 were favourably influenced, so that he considers it by far the best drug for constipation. Its special advantages lie in the fact that it is not necessary to increase the dose after long continued use, and that its action is almost wholly mechanical. The dose is a teaspoonful to three dessertspoonsful a day, according to circumstances. It is best given in soup, mashed potato, or apple sauce. D.

A New Cutaneous Reaction in Tuberculosis.—Von Pirquet (*Berl. Klin. Woch.*, May 20, 1907) found that if tuberculin is introduced into the skin of a tuberculous child there will appear at the point a small papule not unlike the papule of vaccination, at first bright, later more dark red, and lasting about eight days. A small quantity, about two drops, of diluted tuberculin (old) is placed on the skin and a small scarification is made with a sterile lancet right through the drop. Von Pirquet has made 500 tests and obtained a positive reaction in nearly all the cases of clinical tuberculosis in infants. It was not absent in any case of miliary tuberculosis or of tuberculous meningitis in the last stage, or in infants markedly cachectic. The most characteristic reaction was obtained in cases of tuberculosis of the bones and glands. The reaction possesses diagnostic value, principally in the case of patients in the first year of life, and here it may prove of great value in the diagnosis of tuberculosis. In tuberculous animals a similar reaction becoming positive and distinct in twenty-four hours is obtained. The reaction may be regarded as indicating an increased degree of sensitiveness of the skin to infectious material on the part of those suffering at the time with actual infection by the corresponding microbe. D.

Tetany.—Chovstek (*Wien. Med. Woch.*, No. 23) says that all those factors which previously have been considered as being the etiological cause, are merely exciting causes. In individuals affected with tetany, the onset of menstruation, an angina, or, as the author has seen, the injection of tuberculin, is sufficient to excite an attack. The specific cause of the reaction in tetanic individuals is a constitutional one, and is probably associated with a functional disturbance of the parathyroid glands. D.

Suprarenal Hæmorrhage: A Usual Cause of Sudden Death.—Munson (*Jour. Am. Assoc.*, July, 1907) reports a case of collapse and death in which at autopsy the cause was found to be hæmorrhage in both suprarenal glands. Suprarenal hæmorrhage is said to be very common in still-born and very young infants, but in adults it is comparatively rare. Clinically the cases simulated peritonitis or internal hæmorrhage and show symptoms of suprarenal insufficiency (*i.e.*, prostration, loss of weight, diarrhœa) or resemble apoplexy. D.

Lupus Vulgaris Secondary to Tubercular Lymph Glands.—Jones (*Brit. Journ. of Dermatology*, September, 1907) discusses the origin of this disease in the light of an analysis of the cases treated in the light department of the London Hospital. The 923 cases so collected are divided into six groups: (1) 47.3 per cent. begin as a small spot on the face, cheek, or neck; (2) 28.9 per cent. begin on the nose or in the nostril; (3) 11.4 per cent. are secondary to tuberculous glands, either in the scar or in gland-abscesses; (4) 1.8 per cent. arise from mucous membranes, other than the nasal, chiefly the margins of the lips; (5) 1.8 per cent, secondary to tuberculous disease of bone; (6) 8.5 per cent. arise in miscellaneous ways and on various parts of the body. In this connection it is interesting to note that quite a number of patients gave a definite history of the disease, first beginning as a swelling on the cheek, about an inch and a half outside and three-quarters of an inch above the angle of the mouth. The patients stated that this swelling burst and the disease started from that. Dr. Jones says: "Naturally it strikes one that this was primarily a tuberculous focus in the subcutaneous tissue of that region, and possibly a tuberculous lymphatic gland. Such a gland is described by Pourrier, lying on the buccinator muscle, called the facial gland, and believed to drain the region about the angle of the mouth, both inside and out. ('Lymphatics' by Pourrier, translated by Leaf, Chap. V., 2.)" K.

Fatal Case of Acute Lupus Erythematosis.—Short (*Brit. Journ. of Dermatology*, August, 1907) reports a case of this disease which was first described by Kaposi, but which is very unusual in this country. The patient, a woman, æt. 28, gave a history of four months' illness on admission to hospital, when she presented a condition of diffuse swelling at the bridge of the nose and adjacent parts, and over the left malar region a reddened patch about the size of half-a-crown. The first sign of the disease was noticed on the tips of the fingers and toes and on the lobules of the ears where the skin became covered with coarse scales of a dark red colour. On admission the finger tips and toes were red and desquamating and there was slight œdema of the feet. A week later small blebs containing pus appeared on the side of one finger and of one toe near the nails, and the eruption on the face spread considerably and became covered with herpetiform blebs which dried up into crusts. After this small rings of follicular ulcers appeared on the roof of the mouth, the vulvæ became œdematous, and the lymphatic glands generally enlarged, hard and tender. The temperature averaged about 101° F. Five weeks after admission the patient had a convulsion and became unconscious, after which she vomited and her condition improved for a time. A week later the vomiting began again, the face swelled, herpes appeared and, after a few days, twitchings and convulsions were of almost daily occurrence. In the gluteal region several painful subcutaneous nodules appeared, the patient developed pneumonia, and died eight weeks after admission. The urine was always of low specific gravity, pale in colour, reduced in quantity, and contained a small amount of albumen. K.

The Beneficial Effect of One Disease on Another.—Bury. (*The Med. Chronicle*, August, 1907) reports two cases in which it appeared that the occurrence of a second disease had a markedly beneficial effect on an already existing disease from which the patient was suffering. The first patient was a man æt. 44, who was admitted to hospital with symptoms of cardiac muscle failure and signs of mitral regurgitation. This patient remained in hospital for seven weeks without any improvement, at the end of which time he was so bad as to need subcutaneous injections of strychnine. Infection resulted from one of these injections and the patient developed a severe cellulitis of the arm which ended in suppuration. From the date of the onset of the suppuration the cardiac symptoms improved, and shortly after he left the hospital apparently quite well. The second case was that of a man admitted to hospital with symptoms of insular sclerosis, including marked hemi-atrophy of the tongue. He was discharged without much change, but sometime after he had a severe attack of smallpox, on recovery from which his former symptoms began to disappear and in a few weeks he was quite well. Dr. Bury saw him three and a half years later, and says he "could detect nothing wrong with his limbs; the gait was normal; there was no nystagmus and no difficulty in speech. The left half of the tongue, however, was still atrophied." K.

Thiokol and Myrtol.—Dibailow (*Russ. Pract., Avzt.*, 1907. No. 24) has employed these drugs in chronic bronchitis and pneumonia. They were at first used for pulmonary tuberculosis, but more extended experience seems to show that they are valueless in that disease. The present writer has obtained most satisfactory results in 53 cases of bronchitis, and five cases of lobar pneumonia with thiokol. The doses varied from two to seven grains three times daily after meals. The improvement noted consisted in a diminution of the sputum, a lessening of the dyspnœa, and a practical cessation of coughing. None of the objectional symptoms described by Rossi, such as vomiting and headache, were observed. Myrtol was used in 26 cases of chronic bronchitis, the drug being administered in two-grain doses in gelatine capsules. It was well borne and seemed to exert a similar effect to that of thiokol, but less marked. It was particularly useful in fœtid bronchitis. M.

Veronal as a Hypnotic.—As a result of 78 careful observations, and after a study of the literature, Likudy concludes (*Russ. Med. Rundschau*, 1907, Heft. 6., p. 362), that veronal is the best of the newer hypnotics, and formulates the following statements:—(1) Veronal is characterised by the harmlessness and certainty of its action; in 78 per cent. of all cases its action is efficient; the ordinary dose for women should be five grains and for men seven and a half grains. (2) The sleep after taking veronal usually appears after half an hour, and lasts from six to nine hours; its character is the same as normal sleep. (3) High temperature, dyspnœa and pain diminish the hynotic influence of veronal. (4) The most important field for veronal is in functional nervous disturbances, and in the insomnia of pregnancy; after using the drug for a week it is advisable to discontinue it for some days as the organism rapidly becomes habituated to its use. (5) Complications seldom follow its use; at most a little dizziness or headache may occur, but neither are of long duration. M.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Courier.—We have no particular desire to cross swords with Mr. A. A., though ready enough to do so, if occasion requires. In the present instance the challenge is too clumsy and the trap too obvious. If no notice is taken of the document mentioned, it will probably fall flat. If it be commented on it would give it a chance of additional notice. How can one argue effectively on such subjects with people who do not know the rudiments of chemistry?

Sybarite.—We are much interested in the legal anomaly that you point out to us. The point is new, and we will make careful search for information as to the fact. If it turns out that what you believe is true, the matter ought to be dealt with, and cannot be known too widely. At the same time we doubt if it is quite a subject for a medical journal, unless a medical man were directly involved in the injustice. And that, we take it, is not the case.

THE BABU AND THE DOCTOR.

Babu letters, it is to be feared, are, as a rule, either fictitious or considerably edited and embellished. The following one from Assam is as authentic as it is diverting. It is an application from a native to the steamer agent at Dibrugarh (Assam):—

"Respectfully showeth that your humble practitioner is poor man in agricultural behaviour, and much depends on season for the staff of life, therefore he falls upon his family's bended knees and implores of his merciful consideration for a damnable miserable like your honour's humble petitioner. That your humble petitioner was too poorly during last rains and was trying vernacular medicine without effectuality, but was resuscitated by much medicine of Dr. J. Lazarus, which made magnificent excavations in the coffers of your humble servant. That your petitioner has a large family of seven lives, two males and five females, last of whom is milking the paternal mother and is very noiseful, through pulmonary catastrophe in the interior abdomen. That your humble petitioner prays that if there is a place ever so small in your honour's benevolence, this slave will be allowed to creep in. For this act of kindness shall, as in duty ever bound, pray for your honour's longevity and procreativeness."—*London Opinion.*

Hants.—Many thanks for your suggestive letter. The subject was carefully gone into by us a short time ago, and we came to the conclusion that it was better to bear the ills we have than to fly to others that we know not of.

Congress.—The observations on the effect of alcohol on animal life on which you wish for information were made by H. E. Zingler and H. Fühner. They showed that one per cent. of alcohol (ethyl alcohol) added to water in which the embryos of sea-urchins were placed retarded their development. A two per cent. solution not only greatly arrested development, but tended to produce monstrosities, while a four per cent. solution markedly retarded all development.

Demograph.—The word demography is not perhaps a very happy one, and a good many people, we fancy, like you do not grasp its full signification. It does not mean, as was suggested at a congress, "teaching people to write," but is the name of the science dealing with the statistical estimation of populations and such of their conditions as lend themselves to enumeration.

HEATING FOR HEATING'S SAKE.

Business was bad in the Farringdon Road owing to the weather, and a professor selling an invaluable specific had for audience only two very small boys and a hungry-looking tramp. "Now, gentlemen," said the professor, fixing his eye on the tramp, "I don't want you to believe that this 'ere invaluable medicine works miracles. No; you 'as to consider your eatin' and drinkin'. Wot does the 'ighest medical authorities sy? Eatin' from 'abit, they sy, is a prolific cause of hindigestion. You should only heat when you wants to heat." "Oo are you gettin' at?" remarked the tramp indignantly. "I can't eat when I wants to eat, that's wot's wrong with me. And as for drinkin'—gor blimey!"—*Weekly Times of Edinburgh.*

Furuncle.—We are not prepared to recommend the treatment of boils by zinc sulphate baths, as we have no experience of it ourselves, but the details of the treatment are as follows:—Into a large bath an ounce of zinc sulphate is put, making a solution of about 1-1,000. In the usual way no irritation of the skin is caused, but if by idiosyncrasy of the patient there be any, half an ounce should be used subsequently. The baths should be taken three times a week for half an hour at a time. The skin should be rubbed with a rubber sponge after the bath. There is no reason why soap should not be used, except that it does not lather well with the solution.

Scholar.—The question of disinfecting schools was dealt with in a paper at the International Congress of School Hygiene lately held in London. You will find the matter treated there at some length. Some school authorities regularly disinfect their schools. This is certainly the case at Nottingham, Durham, Middlesex, Leeds, Birmingham, Willesden, Dundee, West Ham, and East Riding.

Vacancies.

Dorset County Hospital, Dorchester.—House Surgeon, to reside and board in the Hospital. Salary, £100. Applications to the Chairman of the Committee.

Norwich City Asylum, Hellesdon-next-Norwich.—Resident Medical Superintendent. Salary, £400 per annum, with furnished residence, fuel, light, rates, washing, etc. Applications to Arnold H. Miller, Town Clerk, Guildhall, Norwich.

Jersey Dispensary.—Resident Medical Officer. Salary, £120 per annum, furnished quarters, and attendance. Applications to Secretary.

Farringdon General Dispensary, 17 Bartlett's Buildings, Holborn Circus, E.C.—Resident Medical Officer. Salary, £120 per annum, with apartments, coals, gas, and attendance. Applications to the Honorary Secretary.

Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C.—Senior House Surgeon. Salary, £100 a year, with board and residence in the Hospital. Applications to the Secretary.

Newcastle-upon-Tyne City Hospital for Infectious Diseases.—Resident Medical Assistant. Salary, £104 per annum, with board and lodging, etc. Applications to the Medical Officer of Health, Health Department, Town Hall, Newcastle-upon-Tyne.

Birmingham General Hospital.—Receiving-Room Officers. Salary, £160 per annum. Applications to Howard J. Collins, House Governor.

Tunbridge Wells General Hospital.—House Surgeon. Salary, £100 per annum, with board, furnished apartments in the Hospital, gas, firing, and attendance. Applications to the Secretary.

University of Durham College of Medicine, Newcastle-upon-Tyne.—Demonstrator of Physiology. Salary, £200 per annum. Applications to Prof. Howden, Secretary of the University of Durham College of Medicine, Newcastle-upon-Tyne.

Gravesend Hospital.—House Surgeon. Salary, £100 per annum, with board and residence. Applications to A. E. Thomas, Secretary.

London Temperance Hospital, Hampstead Road, N.W.—Resident Medical Officer. Salary, £120 per annum, with board, lodging, and washing. Applications to A. W. Bodger, Secretary.

Salford Union.—Resident Medical Officer. Salary, £130 per annum, with furnished apartments and attendance in the Infirmary. Applications to F. Townson, Clerk to the Guardians, Union Offices, Eccles New Road, Salford.

Durham University College of Medicine.—Demonstrator of Physiology. Salary, £200 per annum. Applications to Professor Howden, Durham College of Medicine, Newcastle-upon-Tyne. (See advt.)

Appointments.

McWalter, J. C., M.D.Brux., M.A., F.F.P.S.Glasg., D.P.H., Barrister-at-law, Examiner in Medical Jurisprudence to the Apothecaries' Hall of Ireland.

Palmer, F. W. Morton, M.B., B.C.Cantab., Ophthalmic Surgeon to the Teignmouth Hospital.

Phippen, Harry G., M.R.C.S.Eng., L.R.C.P.Lond., Assistant Medical Officer at the Western Hospital, Fulham, London, S.W.

Births.

Macevoy.—On Sept. 11th, at 41, Buckley Road, Brondesbury, London, the wife of H. J. Macevoy, M.D., B.Sc.Lond., of a son

McClintock.—On Sept. 12th, at The Chestnuts, Loddon, Norfolk, the wife of Lawson Tait McClintock, M.B., of a daughter.

Marriages.

Iles—Pink.—On Sept. 12th, at St. Barnabas', Bexhill, Alfred John Hopkinson Iles, M.R.C.S., L.R.C.P., son of Alfred Robert Iles, M.R.C.S., L.R.C.P., of Taunton, to Florence Mabel, elder daughter of Edward Pink, of 5 Gwendolen Avenue, Putney.

Rose—Waller.—On Sept. 14, at Emmanuel Church, West Hampstead, William David Rose, M.B.C.M., of Luton, to Mabel, daughter of Charles Ashton Waller, Long Compton Manor, Warwickshire.

Deaths.

Crowfoot.—On Sept. 11th, at Beccles, Suffolk, William Bayly Crowfoot, M.A., M.B., B.C.Cambridge, aged 29.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, SEPT. 25, 1907. No. 13

NOTES AND COMMENTS.

Examinations for Wives.

WITH all the talk there has been, and rightly been, about maternal ignorance and its lamentable consequences, there has risen a desire that mothers—actual and potential—should be educated in the duties of housewifery and motherhood. No doubt, if the instruction be as good as the intention, such classes will do much to prevent women falling into the mistake of giving children whatever they cry for, or even a "bit of what we 'as oursel's," and they cannot but help in the promotion of a sense of responsibility on the part of mothers towards their children, and thus tend to preserve the physical and moral welfare of the race. Now, the logical corollary to instruction is examination, and there can be no harm in testing the aptitudes of pupils to retain the knowledge that has been imparted in these classes, but we confess to being somewhat staggered at the proposal made in a contemporary that there should be an examination for women before they became wives. The examination craze has reached heights of imbecility which its most ardent initiators could hardly have dreamed of, but if the maidens of Great Britain have to pass an examination before they can become eligible for the honour of a man's hand, we fancy we should range ourselves on the side of the angels and oppose the plan with all possible vigour. The plain fact is that the prettiest girls are notoriously the stupidest, and if none but the ugly girls could get married, whatever result their ability might have on the nature of the infant, it would not take long before there were no types of British beauty left to lighten the burden of a drab world.

Chops v. Logic.

SIR JAMES CRICHTON-BROWNE'S presidential address to the Sanitary Inspector's Association, in which he praised the virtues of a substantial meat dietary, has brought about his ears the clamours of all the food faddists and self-advertising folk who enjoy the notoriety attending free contributions to the September newspapers. It is a curious comment on the influence gained by such folk on the mind of the public that it should be necessary for a well-known medical man to utter such a platitude as that mutton-chops and roast beef are good things to eat, and, still more so, that it should excite any attention in a nation whose boast has always been that beef and beer have built up an empire against which the eaters of sauerkrout, horse-sausage, and frogs' legs rage impotently. In the days before people took to analysing their sensations so minutely, and took more exercise in the open air, beef and beer established their reputation as a dietary by the exceedingly comfortable feelings they produced when taken by tired and healthy people. If it has come to this, that there really are a large number of folk in this country who actually cannot get their ordinary wants supplied by beef and mutton, but find satisfaction only in the cauliflower and lettuce, then we can only deplore the loss of national vigour which such anæmic taste connotes. Indeed, did the vegetarian realise it, he should hide his habits in the corner, for to confess them is to write himself down a subnormal person, and while, we take it, he would not boast of an asymmetry of his face, a high arch to his palate, or any of the stigmata of degeneration, he delights to parade in public the ineffectiveness of his gall-bladder and pancreas.

Southend v. Dr. Nash.

THE Southend Town Council, after a due period of reflection, have made their choice, and decided to give up their medical officer of health, Dr. Nash. The battle is one of great moment, and the issues cannot be too clearly laid before the profession. Dr. Nash was appointed Medical Officer of Health to the Council in 1901 at a salary of £400 a year, the agreement being for three years. In 1904 he was duly re-appointed at £500 a year, and the period of his appointment at that rate expired this summer. The Health Committee proposed his re-appointment at £650, the extra hundred being the normal triennial advance, and the extra fifty being payment for work for the Education Committee. However, when the matter came before the full Council, it was proposed and carried that he should be offered the appointment but for one year, and that the salary should be only £500. Now, this opposition to the Health Committee's recommendation was not dictated by any simple desire for economy, or any suggestion that Dr. Nash had been remiss in his duties. It was, in fact, due to the precise opposite, namely, that Dr. Nash had been too energetic and thorough, and had thereby brought himself into conflict with certain interests of the town. In a question extending over several years it is not possible or wise to apportion blame exactly, but whereas the Health Committee, which may be supposed to know the real merits of Dr. Nash's administration better than anyone, strongly supported him, certain members of the Council were actuated by a spirit of hostility. Dr. Nash refused to accept the rebuff, and would have resigned immediately, but for being persuaded to continue temporarily with a view to the matter being thoroughly thought out.

No "Blacklegs."

THE Council then prepared advertisements for insertion in the medical press, but they found themselves faced with the difficulty that the medical press would not accept the advertisement. Moreover, the medical practitioners of the town, many of whom did not see eye to eye with Dr. Nash, unanimously condemned the action of the Council. Only one man, and he, presumably, unsuitable, came forward to apply for the post, and the Council consequently found themselves in a quandary. Accordingly, on the 17th, another meeting—a long and stormy one—was held, and the Health Committee's recommendation that Dr. Nash be appointed at the increased salary was thoroughly considered. This time the force of the opposition was disclosed, the charges being then made that Dr. Nash had brought the sanitary dangers of Southend too much to the fore, and thereby got the town a bad name. Eventually the increased salary was refused by a majority of one vote, and Dr. Nash's temporary occupancy of his post will consequently expire in a month or two's time. We strongly add our advice to that already given that Dr. Nash be supported in his protest, and that no medical man apply for the post. To do so would be to stultify the effect of the action taken, and to postpone the operation of the urgently-needed principle that a medical officer of health may set himself to remedy wrong without fear or favour. If Southend cannot get a medical officer, the Town Council will be brought to their senses in the most effectual and practical way.

Medical Boycott of Duelling. A curious ethical point has arisen in Sicily by the refusal of the medical practitioners of Palermo to attend duels. The profession of that island, being more civilised than their lay colleagues, see the criminal absurdity of "affairs of honour," by means of which an expert swordsman is at liberty to bully any ordinary folk with impunity, or to have the pleasure of spitting them with his sword if they have enough spirit to resent his insults. This boycott has given rise to a variety of opinions among French medical men who have been interviewed by the *Liberté*. There are those who hold the doctors justified in their action, and there are others who consider that the function of a medical man is to relieve suffering, and that he has no concern with the causes of the dispute by which the suffering was incurred. Now, while it is true it is the doctor's function to patch up a burglar whom he has shot while breaking into his house, it is straining the medical ideal very far to say that medical men are not justified in making a collective, practical protest against a barbarous custom which could not go on but for their connivance. We take it that none would refuse to dress a wounded duellist who was brought to their surgeries, but it certainly is below the dignity of civilised gentlemen to sneak about dodging the police to reach the duelling field in order to assure the minimum of danger to quarrelsome people who seek the arbitrament of the sword. In our opinion, the Palmero doctors are not only justified in their action, but they are playing an enlightened *rôle*, and one which does them much credit. Almost any action would be justified if it succeeded in putting an end to such a ridiculous anachronism as duelling.

LEADING ARTICLE.

A SUPREME NATIONAL HEALTH AUTHORITY.

The proposal to unite the chief local sanitary authorities of the United Kingdom by the common bond of a Central Representative Union is so obviously sound as to deserve close attention on the part of all who may be directly or indirectly concerned. It has emanated from Dr. H. E Armstrong, the well-known Medical Officer of Health for Newcastle-upon-Tyne, at which place an executive committee has been formed. After due consideration, it has been decided to hold a preliminary conference in London of the representatives of the sanitary committees of the county councils, county boroughs and municipal boroughs (metropolitan and provincial) and port sanitary authorities of England and Wales. At this stage of the proceedings it is felt that it would be unadvisable to include all the local sanitary bodies in the United Kingdom, owing to their great number. The circular letter which has been sent out to the chairmen of the invited committees, however, expressly states that every Authority in the Kingdom should be duly represented on the National Authority it is now proposed to constitute. The germ of the movement is contained in the distinction thus drawn between the local and the national handling of questions concerning the public health. Under present conditions local administration is more or less chaotic; nor, in the absence of common standards of comparison and of methods of exchanging views and experiences, and of formulating model codes, can this developmental incompetence be a matter of wonder. It is pointed out in the Newcastle circular that the absence of conformity of action on the part of sanitary authorities generally has been recognised for a long time past, and, on account of the diversity of interests involved, has hitherto been regarded as a matter of almost insurmountable difficulty, as well as a cause of much waste of energy and time in attempting to carry out broad measures of sanitary reform. This difficulty Dr. Armstrong and his supporters hope to overcome by starting a kind of sanitary parliament, to act as a central body and to consist of representatives of every sanitary authority in the United Kingdom. The function of this body would presumably be to draw up responsible recommendations which would be available for the legislature on the one hand, and for local administrations on the other. As the Newcastle Committee remarks, the necessity for such an organisation has been experienced by most of the sanitary authorities of the Kingdom. The movement to provide it has been rightly interpreted as the result of a desire to bring into existence a body which will focus the opinion of all engaged in public health work, and make their experience effective in requiring legislation to promote the object in view. Perhaps the greatest function so far allotted to the proposed union is that of advising the legislature. It is obvious that sanitary authorities, from their daily experience of the working of Public Health Acts, must be familiar with legal shortcomings, just as they must necessarily be the best judges of sanitary defects that are not met by existing legislation. To a great extent a competent central union would be able to frame practical measures for meeting national issues of such tremendous importance and complexity as infant mortality, the pollution of rivers, tuberculosis in man and animals, and the meat and milk supplies. A great public discussion, say, on the housing problem by an assembly of informed debaters could not fail to bring home to the nation with irresistible force the wrongs inflicted upon the community by the jerry builders and the privileged landlord. The impulse to Parliament to pass new building Acts would be of a nature unlike anything at present in existence. Similarly, it is unlikely that after a few years of persistent exposure by the Union of the evils of contaminated drinking-water supplies that Londoners would contentedly continue to drink water drawn from a river extensively polluted by sewage. There is no need to multiply instances. The field is a large one, the workers are earnest and multitudinous, but the problem is to render them articulate and to bring them into touch so that their individual experiences may be crystallised into general propositions of value and authority. The whole scheme, if properly carried out, bids fair to mark one of the most important departures ever yet made in the public health history of the United Kingdom. The first conference, it is announced, will be held in London between November 12th and 15th next. As the future of the movement will largely depend on its reception at the first meeting, we trust that all the local sanitary bodies that have been approached will make an effort to be represented at the preliminary conference in November.

POOR-LAW MEDICAL.

THE recent resignation of the whole of the medical staff of the Fir Vale Union Infirmary, at Sheffield, opens up a subject that has for some time past been in need of revision. With the immediate cause of the resignations we are not here concerned. It suffices for present purposes to know that the conditions of professional work at the Poor-law institution in question have been such that five medical men have taken the serious step of throwing up their posts. Those who have had any extended experience of such positions know that in the majority of cases friction arises from an unwarranted assumption of authority on the part of the lay officials of the institution concerned. In these cases the lay officers are often permanent, while the resident medical officers are young men who have a limited tenure of office. From the necessities of the position, therefore, the guardians are naturally more likely to favour those whom they have known for the longer period of time. Apart from that particular phase there are other and deeper principles involved. One of the foremost of these is the proposition that in a sick infirmary medical control should be permanent. If it were so the public would be spared many of the scandals arising directly out of understaffing in Poor-law infirmaries; scandals which are now only too frequent. The Sheffield case is not sufficiently ripe for discussion. At the same time, it will be well to point out one serious error that has crept into the lay newspapers, namely, the statement that the resignations have been prompted by the local branch of the British Medical Association. As a matter of fact, the question has not yet been considered by that body. In view of the importance to the medical profession of the readjustment of the present unsatisfactory conditions, it is to be hoped that the matter will not be allowed to drop until is has been threshed out between the guardians, the Local Government Board, and the medical profession in Sheffield. We hope to keep our readers fully informed of the course of events.

CURRENT TOPICS.

Poison Epidemic in Essex.

AN outbreak of fortunately mild ptomaine poisoning occurred recently in several Essex villages near Colchester. About fifty persons were attacked, but all recovered within a few days, and the epidemic was ultimately traced to some infected brawn. The incident is one of a far too familiar type, but it is difficult to see how accidents of a similar kind can be altogether prevented. Even in the case of careful and conscientious tradesmen, carrying on their work in a cleanly environment, it is quite possible occasionally to overlook the tainting of so perishable an article as butcher's meat. There is the further fact that meat may be capable of causing disastrous illness, although it bears little or no evidence of the danger by signs appreciable to the senses of sight, smell and taste. The only scientific way that suggests itself of preventing the possibility of contamination would be to have food prepared with aseptic precautions, and stored in a sterile environment, with directions to be consumed within a certain number of hours. In human affairs, however, the counsels of perfection will always have to be modified by the requirements of daily life. Incidentally, in the Essex epidemic, a dog which had stolen some of the incriminated brawn was reported to have suffered severely. This incident, while it afforded valuable evidence to the sanitary authorities, has, at the same time, furnished a somewhat knotty problem for the moralist. In this case Providence seems to have punished alike the guilty dog and his innocent owners, although the one stole his brawn, and the other bought and paid for it.

Germany and Patent Medicines.

THE German legislature usually takes a short cut in dealing with offenders against the public weal. Since 1903 it has completely altered the conditions of the patent medicine trade by compelling the makers to state on each packet or bottle the ingredients and their quantities. Now it has gone a step further and adopted a further plan that bids fair to kill the most noxious of all trades. From October 1st next all written or printed praise of the specific is forbidden, and all public advertisement. No chemist, moreover, who does not know what a patent medicine is made of may supply it without a doctor's order. Why should not a similar law be passed in the United Kingdom? The evil wrought upon the health of the community by the sale of patent medicines is incalculable. The medical man who is scientifically trained in the remedial treatment of disease has no secrets. Why, then, should the ignorant charlatan be permitted to claim for alleged specifics the power of curing manifold maladies? The transaction is, in plain words, a fraudulent attempt to procure money under false pretences. The growing intelligence of the community must one day put an end to a trade that is carried on at the cost of untold injury to the health of the people. What is possible in Germany is surely possible in our own country.

Maternity Homes and Syphilis.

THE recent appearance in a police court of the matron of a maternity home suggests various questions of medical general interest. The institution in question was called a school of midwifery, and one of the witnesses produced a certificate stating she had undergone a course of instruction there, and was qualified to act as a monthly nurse. It will be interesting to learn what control the Central

Midwives' Board had over the institution as regards the quality and the quantity of the teaching. Another point arises out of the evidence of a police surgeon to the effect that a child was suffering from hereditary syphilis of a bad form. In his opinion the condition of the child might have been alleviated by medical attention. So far as can be gathered, there appears to have been no systematic medical treatment attempted. Apart from the merits of this particular case, however, it is of considerable interest to enquire whether the neglect to treat an infant suffering from constitutional syphilis might be legally construed into an act of criminal neglect. A maternity home might reasonably be supposed to have the experience necessary for the recognition of such a malady. It would be obviously a first duty to instruct midwives upon the chief facts of syphilis, both in mothers and in infants. The obligation to provide medical attention probably applies to institutions as it does to other responsible guardians, and not less so in syphilis than in other diseases.

Edible Fungi.

THE recent lamentable occurrence at Ipswich whereby a whole family was poisoned by eating fungi has led to enquiry as to how edible mushrooms may be distinguished. Now, there are two kinds of mushroom. First, the common mushroom (Agaricus campestris), which has a white stem and cap. Underneath the head are a number of gill plates radiating from, but not attached to, the stalk. They are pink in colour, and form the under lining of the head. In the developed mushroom an annulus is found round the stem. In the earlier stages of growth, when the mushroom resembles a solid white button, the annulus is attached to the white covering of the cap or pileus. The colour of the fungus darkens with age. The second kind of mushroom is the Agaricus arvensis. It is also called the meadow mushroom and the horse mushroom. It is the larger of the two, the gills below the cap are whitish instead of pink, and with age they become very dark. It is not as good as the common mushroom for making ketchup, and still less for eating purposes. While the most of people eat mushrooms with relish and impunity, there are others who are liable to attacks of sickness from their use. On the gills of fungi the spores are to be found, and these spores show whether a particular fungus is to be regarded with suspicion or not. Mr. M. C. Cooke, in "British Edible Fungi," describes how the spores of a fungus should be examined. The fungus should be placed on a sheet of paper, with the gills downward, for a few hours or over-night. When removed, a very fine dust is observed to have been thrown down on the paper from the gills. This deposit is either white, salmon-coloured, brown or tawny, dark brown or black. In the common mushroom the spores are of a dark purple-brown. A great number of species which have purple-brown spores are edible, whilst it is very rare indeed for a species with salmon-coloured spores to be worth eating, and some are poisonous. The colour of the gills and of the spores are of considerable importance, and must be taken into account in determining a fungus. Mushrooms ought to be cleaned before being eaten, and rejected if any parasites are found on them.

A Source of Tuberculosis in Pigs.

Now that the identity of tuberculosis in man and in the lower animals is established, we are likely to be faced with many fresh precautions arising logically out of that far-reaching law. An instance in point came recently from a northern town, where the guardians have adopted an attitude that might well be taken as a pattern by all Poor-law authorities called upon to deal with the problem of tuberculosis. A medical man pointed out to his fellow guardians that all waste food collected in the phthisis ward of the local union hospital was placed in the swill-tub, and afterwards sold for the purpose of feeding pigs. The risk of spreading tuberculosis, first amongst pigs, and, secondarily, amongst the consumers of the diseased flesh, is obvious. Of all the lower animals, the pig is one of the most susceptible to invasion by the bacillus tuberculosis. We are pleased to say that the guardians immediately resolved that in future all the waste food from the ward in question should be burned. The matter is deserving of the widest publicity, as it is only by attention to details of this kind that the "white scourge"—as it is sometimes aptly termed—will be one day eradicated. There are many points in connection with waste food to which the attention not only of the public, but also of medical men and nurses, might be drawn with advantage.

The Lord Mayor and the Cripples' Homes.

THE scheme which the Lord Mayor has done so much to promote—namely, the establishment of an institution for cripples, partly hospital and partly educational home, has been greatly helped forward by the gift from the War Office of the Princess Louise Military Hospital at Alton. The value of this property runs to many thousands of pounds, and we believe that such a presentation from a Government to a body of eleemosynary trustees, without consideration, is the first of its kind in this country. As the Lord Mayor has received £50,000 in donations wherewith to start his home, and £60,000 is all that is needed to put it on a firm financial basis, it may be presumed that the success of the institution is assured. It is certainly difficult to see how without this gift Sir William Treloar would have been able to have carried through his scheme in anything like an adequate manner, and now accommodation for only a hundred and fifty will be forthcoming. Yet we seem to remember the statement being made some time ago that £60,000 would relieve all the crippled children in London. While thoroughly recognising the Lord Mayor's kindness of heart in seeking to provide still further for the cripples, it must be hoped that his spirited efforts have not drawn away support from the excellent institutions at present in existence, many of which find it very difficult to keep up their subscriptions-list as it is. Whilst wishing every possible success to the new home, may we express the hope that the committee will place themselves under trustworthy medical guidance as regards the treatment of the children, and eschew the blandishments of interested quacks?

Consumption and Breach of Promise of Marriage.

WE do not know that the fact of a person's suffering from consumption has ever been put forward in this country as a justification for breach of promise of marriage by the other party. In the Supreme Court of Washington, however, a decision has just been given in which the case rested on this plea. It appears that the engagement had been entered into by the man with the knowledge that the woman suffered from consumption. He afterwards broke the engagement on that ground, and the Supreme Court held that he was justified in so doing. There are doubtless good reasons why a woman suffering from phthisis should not marry, but we can hardly understand how a contract can be justifiably broken on account of facts known at the time the contract was entered into. It is more than doubtful whether such a plea would be upheld in this country, but in America there is a much greater tendency to limit the freedom of the diseased or degenerate individual to propagate his kind.

Consumption in the Hebrew Race.

The comparative immunity of the Hebrew race from consumption has always been regarded as one of the facts of racial natural history. That belief, however, has been somewhat rudely shaken by Dr. S. A. Jacob, a non-medical philanthropist, who was until lately President of the Consumptive Aid Association in Leeds. That position he has now resigned in order to devote himself entirely to the formation of a Jewish branch of the Tuberculosis Association. This step was prompted by the rapid increase of consumption amongst his co-religionists. Dr. Jacob has given a powerful description of the miserable houses of the local Hebrew population amongst which the cases are found. It may be gathered that he refers to slum districts peopled by poverty-stricken alien Jews from Russia, Poland and other parts of the Continent, who have of late years invaded the great towns of the United Kingdom. There is, of course, no absolute racial insurance of the Jews against tuberculosis. Given the conditions of bad air, poor feeding, overcrowding, and an unfavourable slum environment, and the Hebrew will contract the disease as easily as the Christian. We presume that Dr. Jacob is alive to the probability that slum tuberculosis is to a certain extent due to infected milk and flesh. Although incapable of exact proof, that is the inference most likely to be adopted by the educated medical man, in view of the recent authoritative finding of the Tuberculosis Commission as to the identity of the malady in man and the lower animals.

Smoke and Disease.

There is little doubt that the constant breathing of smoky, soot-laden air is injurious in some degree to the lungs. Probably the irritation caused by particles of soot is one of the most important predisposing causes of tuberculosis, and it has been shown by experiment that guinea-pigs which had lived in a smoke-laden atmosphere died of pulmonary tuberculosis more quickly than those which showed smoke-free lungs. It is, of course, notorious that people already afflicted with phthisis thrive better in a pure than in a smoky air. Notwithstanding all this, but little support has been given by the medical profession to the movement for the abolition of the smoke nuisance. It is true that in many of the English cities there are by-laws controlling the issue of black smoke, but the problem as a whole has, as yet, hardly been touched. Possibly in the long run the solution will be found in the substitution of coal-gas for coal for manufacturing purposes, as has been done on a limited scale in South Staffordshire and some other districts. It has been found possible there to produce at cheap rates a gas very suitable for manufacturing purposes, though useless as an illuminant.

PERSONAL.

Queen Wilhelmina and Prince Henry were present at the opening of the International Congress of Psychiatry and Psychology held at Amsterdam at the beginning of this month.

The Annual Presidential address of the West London Medico-Chirurgical Society will be given on October 4th at 8.30 at the West London Hospital, the subject being "The Relationship of Disease of the Ear, Nose, and Larynx to General Medicine." The new President is Mr. Richard Lake.

It is announced that Dr. H. P. Motteram has been nominated for the Mayoralty of Smethwick.

Dr. C. T. Wright, Professor of Midwifery at Leeds University, has resigned his office after forty years' service in connection with the Leeds Medical School.

The Royal Dental Hospital of London, Leicester Square, has received £250, less legacy duty, from the Executors of the will of the late John Lawrence Toole, Esq.

Dr. George Newman has resigned his post of Medical Officer to the Finsbury Borough Council, on his appointment as Chief Medical Officer to the Board of Education.

Professor Francis Gotch, M.A., D.Sc., F.R.S., will present the prizes awarded by the Faculty of Medicine in the large hall of University College, Bristol, on October 1st.

The Order of the Hospital of St. John of Jerusalem in England has been conferred on Dr. Arthur J. Evans, of Liverpool, for his services to the wounded at the earthquake in Jamaica.

The Second Norman Kerr Lecture of the Society for the Study of Inebriety will be delivered by Dr. Robert Welsh Branthwaite, on Tuesday, October 8th, at 20, Hanover Square, London, W.

The Inaugural Address of the Winter Session of the London School of Clinical Medicine will be delivered by Sir Richard Douglas Powell, Bart., K.C.V.O., M.D., on Tuesday, October 8th.

First-Class Hospital Assistant P. S. Ramachandrier, of the Mysore Medical Service, has been awarded the prize offered by the *Indian Medical Gazette* for the best essay on the prevention of plague.

Sir Arthur Conan Doyle was married very quietly on September 18th at St. Margaret's Church, Westminster, to Miss Jean Leckie, daughter of Mr. and Mrs. James B. Leckie, of Glebe House, Blackheath.

At Friday's session of the International Tuberculosis Conference, Dr. Klemens Pirquet presented an interesting report on his experiments in the inoculation of infants with tuberculin in order to detect the presence of tuberculous germs.

A Clinical Lecture
ON
CONGENITAL ANOMALIES OF THE EYE. (a)

By SYDNEY STEPHENSON, M.B., F.R.C.S.Ed.,

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The expression "congenital anomalies of the eye" chosen by the Reader in Ophthalmology for the title of this lecture, is in itself somewhat anomalous—at least, without further definition. As generally applied, however, it means some malformation in structure or some anomaly in function present when a baby is born, or (much more rarely) arising soon after birth, as in the curious condition known as "opaque nerve-fibres of the retina." In short, it is usually a birth anomaly—that is, an inherited as distinguished from an acquired defect. We must carefully exclude those defects, as corneal opacities, paralysis of the ocular muscles, irido-dialysis, ptosis, ectropion, and so forth, which are liable to result during the progress of birth by the use of instruments and otherwise.

There is perhaps no part of the human body whose congenital anomalies are more numerous and important than those of the eye and its appendages. This is doubtless connected with the extremely complex structure of the eyeball. The readiness with which practically every part of the eye can be examined, too, has led to the discovery of many defects that would probably have escaped attention in any other organ of the body.

Many of the so-called congenital anomalies of the eye, however, are of interest merely from the embryological point of view, but others, such as infantile glaucoma, microphthalmia, cryptophthalmia, and coloboma of the choroid, may result in such defective sight as to render them matters of importance to the practising surgeon. In this event such malformations may rightly be looked upon as "congenital diseases" if only for the purpose of distinguishing them from the others, which may be called "congenital defects."

At the outset we are constrained to confess our essential ignorance of the causation of many congenital anomalies of the eye. Certain of them, particularly perhaps the conditions known as opaque nerve-fibres and ectropion of the uveal layer of the iris, appear to represent a reversion to a type found in the lower animals, and a similar explanation, as will be explained later, has been applied by Mr. E. Treacher Collins to account for cases of infantile glaucoma. In other words, these are examples of atavism. Many anomalies may be accounted for by delay, failure, or perversion of the normal processes of development. This factor adequately explains many of the deformities, among which may be mentioned persistent pupillary membrane and hyaloid artery, and, in particular, coloboma of the choroid downwards. At the same time it is inadequate to account for some others, such as coloboma of the eyelids, cryptophthalmia, and congenital staphyloma.

Two alternative explanations have been offered for some of these cases:—(1) an inflammation of the tissues of the eye during the sojourn of the fœtus in its mother's womb; and (2) the influence of adhesions between the amnion, on the one hand, and the integument of the fœtus, on the other.

(1) The theory of intra-uterine inflammation (closely connected with Deutschmann's name) is capable of explaining certain malformations, as congenital leucoma and staphyloma, which it is difficult or impossible to account for on developmental grounds.

(2) Adhesions are known to be liable to occur when the quantity of amniotic fluid is unusually scanty, as in cases of oligo-hydramnios. But many such adhesions are now believed to be the cause of spontaneous amputation, of encephalocele, and of fissures of the face, lips, or jaw. Coloboma of the eyelids could be satisfactorily accounted for on the adhesion theory, as could also a singular congenital condition described by Schapringer as "epitarsus," in which adventitious folds of conjunctiva exist upon the inner surface of the upper eyelid.

It is impossible that more than one of the foregoing factors may come into play in the production of certain malformations. Thus, an arrest of or perversion in development may be the direct or indirect outcome of an intra-uterine inflammation, and so forth.

Another point is that our knowledge of the development of the human fœtus is still incomplete. It may accordingly be assumed that some anomalies that cannot at present be explained on developmental grounds may yet be accounted for in that way when we comprehend more completely the processes of development, normal and abnormal, as we some day shall surely do. This suggestion is exemplified by the modern explanation of so-called "central coloboma of the choroid," *i.e.*, a more or less circular defect in the choroid occasionally met with in the neighbourhood of the macula lutea. It is difficult to account for this defect as connected in any way with the fœtal ocular cleft, which, as will be explained in detail later on, develops early in fœtal life and is directed downward. In order to meet this anatomical stumbling-block, the ingenious but unconvincing hypothesis was propounded that the eye rotated 90 deg. during its development. The explanation of the anomaly appears to lie, however, in the occasional existence of a subsidiary fœtal cleft, of which examples have been seen in some of the lower animals, as the sheep, the chicken, and the calf.

Other factors that can scarcely remain without influence in the causation of anomalies of the eye, as of other parts of the body, are syphilis, diseases of the placenta, or fœtal membranes, and general conditions, such as tuberculosis and alcoholism, in the parents.

As to the influence, if any, played by "maternal impressions" in determining congenital anomalies, we remain in complete ignorance.

The transmission of certain eye defects, such as irideremia and ptosis, opens up large and complex questions, not peculiar to ophthalmic work, upon which no consensus of opinion has yet been reached.

Before describing some of the more important abnormalities, something should be said in outline as to the development of the eye, perhaps the only subject connected with the eye not yet discussed in the post-graduate course of ophthalmology provided by the University of Oxford.

Development of the Eye.

At a very early stage in fœtal life, at a time when the nervous system is represented merely by a narrow tube provided at one end with certain dilatations known as the three primary brain vesicles, the rudiment of the eyes appears as a hollow bud, called the primary optic vesicle, arising from each side of the anterior primary cerebral vesicle. The hollow connection between the two vesicles, ocular and cerebral, becomes narrowed, is occupied by vascularised mesoblastic tissue, and is eventually differentiated into the optic nerve.

The primitive ocular vesicle, in common with the rest of the embryo, is covered with a layer of closely-packed cells, the epiblast. Enclosed within the epiblast lie the so-called mesoblastic cells. The hypoblast takes no share in the formation of the eye.

Now the cells of the epiblast at a point corresponding to the optic vesicle, become both thickened and more numerous, so that several layers of embryonic cells are closely packed together at that point. This collection of cells represents the rudiment of the crystalline lens. The primary ocular vesicle lying contiguous to the lens rudiment becomes pushed back, like the finger of a glove, in such a way as to produce a pouch, of which the closed end is directed towards the vesicle. This, which is known as the secondary ocular vesicle, is merely the primary ocular vesicle folded upon itself—invaginated, as it were—and like the latter, is composed of epiblastic cells. Simultaneously with these changes, the collection of epiblastic surface cells becomes separated from the superficial epiblast, and at last lies quite apart from the last-named. The surface epiblast grows over the detached group of cells, the edges of which cohere, so as to form a closed sac, known as the lens sac or vesicle. At a later period of development this sac becomes converted into a solid body, the crystalline lens, by the continued growth of its component epiblastic cells.

(a) A Clinical Lecture delivered July 19th, 1907, in the Post-Graduate Course of Ophthalmology in the University of Oxford.

While these changes are going on, the lower aspect of the primary optic vesicle becomes invaginated by a process of mesoblast, a tissue which surrounds the optic vesicle. The optic cup is accordingly incomplete below, the hiatus being known as the fœtal ocular cleft, a structure of considerable importance from our present standpoint. In mammalia the mesoblast pushes its way through this fissure, carrying a vessel with it, so as to reach the interior of the eye, where it separates the lens rudiment from the rudiment of the retina, and eventually forms the vitreous humour. At a subsequent period (in man during the sixth or seventh week of life) the edges of the cleft unite, with the consequence that the eye again becomes a closed spherical sac. A delay in closure accounts more or less satisfactorily for coloboma of the choroid downwards.

The two layers of the secondary optic vesicle speedily commence to differentiate, so that the internal layer eventually forms the retina proper, and the external, the pigmented epithelium appertaining to that structure. The rudimentary choroid is produced from mesoblastic tissue lying outside the optic vesicle. Similar tissue also pushes its way between the outer epiblastic layer and the lens rudiment, and produces the rudiment of the cornea. The epithelium of the cornea, however, is the product of the outer epiblastic layer of cells. The sclera is a mesoblastic structure.

The fœtal lens is provided with special provision for nourishment in the shape of a vascular enveloping capsule, the tunica vasculosa lentis, the anterior portion of which is known as the pupillary membrane. This is developed as early as the second month, and, its work having been finished, should be absorbed shortly before birth. The familiar appearance known as persistent pupillary membrane is due to the survival of portions of the membrane.

The tunica vasculosa lentis obtains its blood supply from a branch of the central artery of the retina, the forerunner of which enters the eyeball through the fœtal ocular cleft along with the intruding mesoblastic tissue. The hyaloid artery, an offset from the central artery of the retina, passes through the vitreous from the optic nerve to the posterior pole of the crystalline lens, enclosed in the canal of Cloquet. Persistence of this vessel, which in rare cases may even continue to carry blood, is one of the best-known and most striking congenital anomalies of the eyeball. Traces of the anterior attachment of the hyaloid artery to the lens are, in my experience, quite common, appearing as a tiny grey opacity situated on the posterior surface of the lens somewhat to the inner side of the posterior pole. Several observers have described appearances which they considered pointed to persistence of the canal of Cloquet.

The eyelids are produced at an early period by two folds of epiblast, together with included mesoblastic tissue, growing one from above and the other from below the cornea. They are not formed, so far as we know, from several centres, as they should assuredly be if deficiencies were to be explained on developmental grounds. The rudimentary lid-folds eventually meet, and become united along their edges by proliferation of the epithelium. In man this temporary closure of the conjunctival sac begins in the third month, and undergoes retrogression a short time before birth (Hertwig), although in rare instances babies are born with a more or less complete union between the eyelids (ankyloblepharon).

The lacrymal gland is formed by budding of the epithelium of the conjunctival sac. The buds, at first solid, gradually become hollowed out. Absence of the lacrymal gland has been described, but in most instances upon somewhat slender evidence, such as the mere absence of the tears.

The lacrymo-nasal duct is formed from a solid rod or ridge of proliferated epidermic tissue, which extends from the mesial side of the eye into the nasal cavity. This solid cord becomes hollowed out by liquefaction of its contents. Should differentiation be delayed, we may have the condition of so-called "congenital dacryocystitis," which is not infrequent in newly-born children.

Congenital Anomalies.

In describing the congenital anomalies of the eye, I shall attempt a rough classification in consonance with what has already been said as to the cause of the several conditions—I. Anomalies due to arrested or perverted processes of development. II. Anomalies due to amniotic adhesions; and III. Anomalies due to intra-uterine inflammation.

I.—Anomalies due to Developmental Defects.

Defects due to developmental anomalies form the largest group. We shall describe as perhaps the most important members of this group, persistent pupillary membrane, coloboma of the iris, lens, and choroid, irideremia, opaque nerve fibres, ptosis, persistent hyaloid artery, certain developmental anomalies of the eyelids and lacrymal apparatus, and, lastly, dermoid tumours of the eyeball and elsewhere.

Persistent Pupillary Membrane.—It is not very rare to find, on an attentive examination of an eye, one or more fine strands of tissue arising from the anterior surface of the iris, near the small circle, or corona iridis, and passing to an insertion elsewhere in the corona. These are examples of persistent pupillary threads. This is one of the commonest congenital anomalies of the eye. For instance, it was present in 68 of 3,414 eyes, or in 1.99 per cent., examined by me some years ago (*Trans. Ophthalmological Society*, Vol. XIII., 1893). It is usually limited to one eye, and the anomaly is apt to reproduce itself in several members of the same family. As a much rarer condition, the filaments may be so extensive and thick as actually to interfere with sight, and it has now and then been found necessary to treat such cases surgically. As might be expected, persistent pupillary membrane is not infrequently associated with other congenital deformities of the eye, such as microphthalmia, opaque nerve fibres, congenital crescent of the optic disc, and various forms of cataract and colobomata. A rare but interesting association is with anterior synechia, as in cases reported in this country by Silcock, Treacher Collins, and Ballantyne. The distinction between persistent pupillary membrane, on the one hand, and posterior synechia, on the other, can generally be established without difficulty by careful examination of the eye. It must not be forgotten, however, as in a case figured by Fuchs (*Text-Book of Ophthalmology*, second American edition, 1899, p. 292), that the two conditions may co-exist. It has been suggested that pupillary remains are likely to disappear during the earlier years of life. Although my own figures lend no support to such a view, there is nevertheless a certain amount of direct evidence to show that absorption may occur after birth (Hirschberg).

Coloboma of the Iris.—Coloboma iridis is the name applied to a congenital cleft, often affecting both eyes, much resembling the result of a cleverly-made iridectomy. The cleft is directed downwards, although it may have a slight inclination inwards or (less commonly) outwards. It may be small, or, on the contrary, extend from the pupil to the ciliary body. It is not infrequently associated with a coloboma of the choroid. A "bridge coloboma" is a coloboma of the iris which is crossed by one or more bands of tissue pigment or pupillary membrane, as the case may be.

Coloboma of the Lens.—In this condition the crystalline lens shows a defect, almost always in the lower margin. The deficiency is generally notch-like and single, although Meyer (*Rev. Générale d'Ophtalmologie*, January, 1893) has reported a case in which a couple of gaps existed at the lower edge of the lens of one eye. In coloboma of the lens it is not uncommon to find the fibres of the suspensory ligament to be absent from an area corresponding to the deficiency in the lens. This observation is of interest, since it has a bearing upon the explanation of the production of the deformity. It is thought that the continued growth of the lens equatorially is due to centrifugal traction exercised by the fibres of the suspensory ligament (E. T. Collins). Hence, a limited deficiency of the fibres would entail as its necessary consequence maldevelopment of the corresponding part of the lens—or, in other words, the production of a coloboma. The explanation of the curious case reported by Mr. R. W. Doyne (*Trans. Ophthal. Society*, Vol. XI., 1891, p. 220), where coloboma of iris and choroid was associated with a projection from the corresponding part of the lens, is still to seek.

Coloboma of the Choroid.—Colobomata of the choroid may be described as (*a*) typical, and (*b*) atypical. Both forms have what may be called a fissurial origin.

(*a*) Typical cases show, when examined with the ophthalmoscope, a larger or smaller area of nacreous exposed sclera, extending downwards from the optic disc towards the visible periphery of the fundus oculi. The optic papilla may or may not be involved. The exposed sclera is often ectatic—that is to say, thrust outward, forming what is sometimes called the "scleral protrusion of Von Ammon." The exposed area generally shows here and there pigment and small vessels. Retinal vessels may cross the surface of the coloboma. Eyeballs containing colobomata are often much smaller than normal—microphthalmia. Even when the dimensions are good, colobomata usually produce a gap in the field of vision, and owing to imperfect differentiation, sight is often extremely poor. Coloboma of the choroid, according to Fuchs, "is in a marked degree transmissible by inheritance." Other defects of the eye, particularly coloboma of the iris, are commonly associated with coloboma of the choroid. With regard to the explanation of the condition, it is usually taught that coloboma arises from incomplete closure of the fœtal ocular cleft. To this view Mr. E. T. Collins has opposed the fact that in some instances the retina exists over the cleft in the choroid. This he attempts to explain by an abnormal adhesion between retina and mesoblast, whereby if this occurs before closure of the fissure, the coloboma is devoid of a retinal covering, and, if after, the retina is present, so that no scotoma exists in the field of vision.

(*b*) Apart from the condition described above, deficiencies in the choroid may occur in practically any part of the fundus oculi. We then speak of atypical coloboma. The most striking of these forms goes by the name of "coloboma of the macula," a condition in which a round or oval area of sclera is exposed in the region of the yellow spot. Its size is generally several times that of the optic disc. It is often bordered by pigment, and crossed by pigment or by vessels. The retina may or may not be present, as judged by the course of the retinal vessels and by the presence or absence of a scotoma in the field of vision. Sight is generally defective in such cases, which not infrequently develop a squint, convergent or divergent, as the case may be. The origin of macular colobomata has given rise to considerable difference of opinion, and the question even now cannot be said to have passed beyond the realms of controversy. Thus, by Nettleship and others they have been assumed to be due to severe fœtal inflammation of the parts; by Lindsay Johnson that they represented degenerated nævi; and, lastly, by v. Kölliker and others that they were connected with the fœtal ocular cleft. In order to account for the fact that while the ocular cleft was directed downwards while the coloboma was situated in the macular region, it was assumed that the eyeball underwent a rotation of 45 or 90 degrees during its development. This view has now been given up. The modern theory is that the defect originates from incomplete closure of a subsidiary ocular cleft occupying the position of the future macula. Such atypical clefts were found as long ago as 1858 by V. Ammon in the eye of the chicken and the sheep, and more recently Van Duyse (*Rev. Générale d'Ophtalmologie*, Tome XX., 1901, p. 119) has demonstrated such a cleft in a calf.

Irideremia.—It is doubtful whether the iris is ever wholly absent. In the cases to which the name "aniridemia" is sometimes applied, critical examination (supposing that to be possible) generally reveals the fact that remnants of the iris are present in the shape of fragments of tissue situated towards the periphery of the anterior chamber. In some of the cases, indeed, as in two brothers shown by me at the Ophthalmological Society (*Transactions*, Vol. XVI., 1896, p. 184), a narrow rim of iris, not exceeding 0.5mm. in width, was present. The condition affects both eyes. Defective sight and nystagmus are the rule. Heredity is a marked feature. This is well shown by a series of cases recently reported by Dr. T. K. Hamilton (*Ophthalmoscope*, October, 1905), where a father and three children (two girls and one boy) were found to suffer from irideremia.

Opaque Nerve Fibres.—There is, perhaps, no congenital anomaly of the fundus oculi that presents more characteristic ophthalmoscopic appearances than so-called "opaque" or "medullated nerve fibres of the retina." The glistening, brush-like processes of beautiful white hue, radiating from the optic disc into the neighbouring fundus, form a picture that, once seen, is not readily forgotten or mistaken for anything else. The condition finds its anatomical explanation in the fact that the medullary sheaths of the nerve fibres, which normally cease abruptly at the lamina cribrosa, are regained by some of the nerve fibres at the margin of the optic disc, and are continued into the retina as such for a longer or shorter distance. When examined with the microscope, the medullated fibres are varicose, owing to the existence of small globular or fusiform swellings along their course, but it has been suggested that these are so many artefacts. In certain animals, as the rabbit and the Tasmanian devil, opaque nerve fibres occur normally. It has been pointed out by V. Hippel (V. Graefe's *Archiv für Ophthal.*, Band XLIX, 3, p. 591) that the appearances in the rabbit do not develop until about three weeks after birth. The same writer maintains that a similar observation holds true in man. Strictly speaking, therefore, opaque nerve fibres is not a "congenital anomaly." Medullated nerve fibres is not a common abnormality. According to some figures I published last year (*Ophthalmoscope*, December, 1906), dealing with the eyes of 4,212 children, the anomaly was present in 29 cases, or 0.68 per cent. of the entire number; 72 per cent. of the cases were unilateral, and 27 per cent. bilateral. My statistics further brought out the fact that opaque nerve fibres were, roughly speaking, twice as common in the eyes of males as of females. With respect to the ophthalmoscopic appearances of my own cases, the commonest was that of one or more white, comet-like processes extending into the fundus from the upper or the lower edge of the optic disc or from both of those positions. In a much smaller number of cases the optic papilla was more or less surrounded by the glistening masses. In a single instance did the opaque fibres encroach upon the optic disc itself. In four eyes the rare condition of "eccentric" nerve fibres was noted—that is to say, areas of medullated fibres not in visible connection with the optic papilla. Cases of this description have been described by Frost, Randall, Dodd, Nettleship, Blascheck, Ulbrich, and Hawthorn. Before leaving the subject, it may just be said that opaque nerve fibres have been known to disappear in cases of optic atrophy (Sachsalber, Nettleship), or of glaucoma (Frost), presumably from degeneration of the fibres.

Pseudo-Neuritis.—The next anomaly to be described has received the name of "pseudo-neuritis," or the "hypermetropic disc." The condition is a common one both in children and in adults. In order to ascertain its frequency in the class first-named, some few years ago (*Reports of the Society for the Study of Disease in Children*, Vol. III., 1903, p. 342), I examined the eyes of 114 children, whose ages ranged from 2 to 16 years. Of the total number, I found as many as 26—that is, 22.80 per cent.—presented a greater or less degree of pseudo-neuritis. It is rather a singular coincidence that Dr. H. C. Bristowe (*Ophthalmic Review*, 1891, p. 321) found the condition to exist in 29 amongst 125 patients—that is, in 23.2 per cent—or in almost the same proportion as that given above. Some of Dr. Bristowe's best marked cases were met with in individuals over 30 years of age. The ophthalmoscopic appearances of pseudo-neuritis vary from a slight haziness to a decided woolliness of the nasal edge of the optic disc, or in extreme examples to a diffuse blurring of the papilla. The slighter grades present a deceptive resemblance to a commencing optic neuritis, while the more pronounced may be readily confounded with a well-developed optic neuritis. The change, although invariably bilateral, is not necessarily equal in degree as regards the two eyes. Two other ophthalmoscopic appearances are commonly associated with pseudo-neuritis—(1) traces of glistening connective tissue alongside the central vessels of the optic papilla; and (2) some tortuosity of the retinal arteries and veins over the fundus generally. How can we distinguish between pseudo-neuritis, on the one hand, and true neuritis, on the other? The main diagnostic points appear to me to be:—1. Pseudo-neuritis is a congenital condition, neither receding nor advancing, no matter how long a case may remain under observation. True neuritis, on the contrary, begins, attains its height, and is then replaced by atrophy or (very rarely) by recovery. Therefore, if the disc become blurred while a patient is under observation, or if blurring become more marked under those conditions, we may safely conclude that we have to deal with veritable optic neuritis. 2. Normal sight and visual field are points against the diagnosis of neuritis. 3. In pseudo-neuritis the disc, in my experience, is never appreciably swollen, although, judging from the appearance of the retinal vessels, it often appears to be so. In reference to this point I note that the latest book *on diseases of the eye*, by Mr. J. Herbert Parsons, contains the caution not to diagnose pseudo-neuritis "unless at least 2D. of swelling can be demonstrated" (p. 397). The exact etiology of pseudo-neuritis is not known, although my own investigations render it certain that it is a congenital condition. Certain writers regard it as the expression of an actual hyperæmia or congestion of the optic disc, due to eye-strain produced by hypermetropia or hypermetropic astigmatism. Hence the name "hypermetropic disc." With this view I am unable to agree, for two reasons—first, if the condition is caused by hypermetropia, it should be relatively more frequent and assuredly more pronounced in the higher than in the lower grades of hypermetropia. The figures at my disposal, however, prove that such is not the case. Secondly, it should undergo an improvement when eye-strain is relieved by suitable glasses, but I have repeatedly satisfied myself that such is not the fact. Moreover, pseudo-neuritis may occur in association, not with hypermetropia, but with myopia or myopic astigmatism. If it is more frequent in hypermetropia, it is simply because in children that condition is at least five times as common as the reverse condition, myopia. I may say that my investigations justify me in claiming that pseudo-neuritis is relatively as common in the one condition as in the other. Accordingly, I reject the name of "hypermetropic disc" unconditionally. I regard pseudo-neuritis as a congenital non-differentiation of the optic disc, a view supported by the frequent existence of shreds of connective tissue and also by the state of the retinal vessels.

Ptosis.—Ptosis may be counted among the commoner congenital defects. It may be complete, or almost so, but is usually incomplete, and both eyes, as a rule, are affected. It may be so slight as scarcely to attract attention until the child looks upwards. When ptosis is marked enough for the eyelids to cover the pupils, the patient manages to see by throwing his head backwards and at the same time evoking the action of the occipito-frontalis muscle. This gives such patients a very characteristic appearance. An interesting point about congenital ptosis is that the condition is not seldom associated with defective movements of the eyeball upward; other defects of movement are more rare. Many cases have now been recorded in which the ptosis became modified during movements of the jaw, such as occur during suckling or mastication. Similar modification has been known to take place when the eye is adducted or abducted. These cases have an interesting bearing upon the innervation of the muscles concerned, and are thought by some to confirm the theory of Mendel, according to which the levator palpebræ superioris is supplied not only by the third nerve, but also by fibres belonging to the fifth cranial nerve, which supplies the muscles of mastication. With regard to the explanation of congenital ptosis, in some cases the levator has been found to be absent, replaced by fibrous tissue, inserted abnormally, or imperfectly developed. The alternative view—namely, that the defect is due to aplasia of the nerve nuclei—is supported by a case of Wilbrand and Sänger (*Die Neurologie des Auges*, 1900), where such changes were found in a man afflicted with congenital ptosis, who died at the age of 47 years.

Persistent Hyaloid Artery.—As already explained, up to a certain period of fœtal life, the hyaloid artery runs from the optic disc through the vitreous to the lens, where it breaks up into a vascular plexus, in order to nourish the enveloping membrane of the crystalline, the so-called capsulo-pupillary membrane. Its persistence in whole or in part is responsible for several congenital anomalies of the eye. For example, in typical form it may persist as a blood-bearing vessel, originating from the optic disc, and reaching to the hinder surface of the lens or to some structure in the neighbourhood of the latter. More commonly, however, one sees merely a greyish cord, attached at one end to the disc, and at the other to the lens or else lying free in the vitreous. The vestige, again, may reveal its existence as a mere tag of tissue, attached to the optic papilla, and moving in response to the excursions of the eyeball. In connection with the hyaloid artery, it may be well to recall the fact that in some animals, as the frog, the vessels of the vitreous persist throughout life.

Anomalies of the Eyelids.—A congenital anomaly of the eyelids that seems to be connected with perverted development was described by me some years ago (*Trans. Ophthalmological Society*, Vol. XIV., 1894, p. 13), under the name of congenital trichiasis. The condition, which is not exactly rare, affects the lower lid of one or both eyes. It is characterised by the fact that more or less of the free border of the lower lid is concealed behind a horizontal fold of skin the mechanical effect of which is to push the lashes upwards, with the consequence that they come into contact with the surface of the eyeball. The cilia appear to be normal, except as regards their direction. The intermarginal space is almost, if not quite, normally situated. The condition may be combined with epicanthus. Heredity is marked. The condition, I believe, depends essentially upon a relative maldevelopment of the tarsus of the lower lid. A more pronounced maldevelopment of that structure, as suggested by Guibert (*Archives d'Ophtalmologie*, February, 1892), would produce the exceedingly rare condition of congenital entropion. A few cases have been known (Jago, Streatfeild) where patients could invert the lower lid at will.

Another interesting but very uncommon malformation affecting the cilia goes by the name of distichiasis, of which I reported a typical case to the Ophthalmological Society in 1901 (*Trans. Ophthalmological Society*, Vol. XXII., 1902, p. 192). This malformation is marked by the existence as a congenital condition of a second row of lashes lying behind the normally placed ones. Upper as well as lower lid may be involved. Mr. A. R. Brailey (*Trans. Ophthalmological Society*, Vol. XXVI., 1906, p. 16) examined microscopically a small piece taken from the upper eyelid of a patient with distichiasis. He found that the most striking feature was absence of the Meibomian glands. Kuhnt regards distichiasis as a congenital condition in which the Meibomian glands have been replaced by a row of accessory cilia with all their attributes as sebaceous glands. The influence of heredity was well shown by Erdmann's cases (*Zeitschr. für Augen-*

heilkunde, May, 1904), which occurred in three generations of the same family, affecting grandmother, mother and child.

Anomalies of the Lacrymal Apparatus.—In a singular case reported by A. S. Morton (*Trans. Ophthalmological Society*, Vol. IV., 1884, p. 350), there was a congenital absence of lacrymation as regards one eye, and in another case by G. Sommer (*Klin. Monatsbl. f. Augenheilk.*, 1903, Band I., p. 482) as regards both eyes. It does not quite follow that the lacrymal gland was absent, although that was actually proved to be the case in an instance of cryptophthalmia examined by Van Duyse. Fistula of the lacrymal gland has been reported by several authors, as Mackenzie and McGillivray. As relatively common conditions the puncta lacrymalia may be absent, replaced by a shallow groove, or blocked up—all as developmental anomalies. The puncta, moreover, may be multiple. By far the commonest and most important anomaly, however, is due to the imperfect differentiation of the naso-lacrymal duct, together with subsequent infection, a condition to which the name "congenital dacryocystitis" is sometimes applied. Should canalisation of the duct be incomplete at birth, it needs only infection by pyococci or other organisms, as the pneumococcus, to cause a discharge of muco-pus from the puncta. The infection, indeed, may occur in the maternal passages, in which event the baby is actually born with a discharging lacrymal sac. In other cases, which perhaps form the majority, the infection is *post-partum*, so that the characteristic appearances do not manifest themselves for several days after birth.

Dermoids.—Dermoid cysts or growths are found with tolerable frequency, either alone or associated with other anomalies, upon or about the eye. All of them are to be explained by epiblastic sequestration taking place while the embryonic clefts are in process of closure. They thus form one of the best examples of the well-known embryonic hypothesis of Cohnheim. Few of the dermoids about the eye deserve the more dignified title of teratomata—*i.e.*, growths which include highly organised structures such as bone or teeth. The commonest place for a dermoid to occur is at the outer end of the eyebrow, where it forms a lenticular swelling, not attached to the skin. These small growths seldom penetrate deep into the orbit. It is therefore more correct to speak of them as "peri-orbital" than as "orbital." Their wall contains some or all of the elements found in skin, while their contents consist of sebum, or—much more rarely—of oily liquid—the so-called "oil cysts." Although the cysts are, of course, congenital, yet they may grow considerably subsequent to birth. I have known them appear more or less suddenly after injury to or operation on the parts. The peri-orbital dermoid may occur at the inner side of the eye, near the root of the nose, a position in which it must be carefully distinguished from a meningo-encephalocele, now believed by many to result from intra-uterine hydrocephalus. On the other hand, true orbital dermoids are extremely rare. I have seen one case only of the kind. The dermoid of the eyeball usually takes the form of a small, solid, whitish growth, of firm consistence, astride some part of the limbus conjunctivæ, as a rule, on the lower and outer aspect. Fine hairs may protrude from the surface of the dermoid, and towards puberty these may grow to inordinate length. In Wardrop's famous case (*Essays on the Morbid Anatomy of the Human Eye*, 1808, p. 31), upwards of a dozen long and very strong hairs grew from the middle part of such a tumour, passed between the eyelids, and hung over the cheek. The patient remarked that these hairs did not appear until he advanced to his sixteenth year, at which time also his beard grew. Dr. Argyll Robertson, under the name "trichosis bulbi," has described (*Trans. Ophthalmological Society*, Vol. XIV., 1894, p. 196) a similar but slighter growth of hair from a dermoid thickening of the ocular conjunctiva. The last form of dermoid to be mentioned appears beneath the ocular conjunctiva, usually in the interval between the insertion of the superior and external rectus tendons, as a soft, fatty-looking mass, the conjunctiva over which may show no particular changes to the naked eye. These growths, formerly spoken of as "congenital fibro-fatty tumours," are now generally recognised to be lipo-dermoids. They are not encapsulated, and their contained fat is continuous with that belonging to the orbit. Their complete removal is therefore an impossibility.

II.—ANOMALIES DUE TO AMNIOTIC ADHESIONS.

As explained earlier, certain anomalies of the eye are now believed by many to be due to the bad effects upon development exercised by adhesions between the amnion, on the one hand, and the tegument of the fœtus, on the other. As to the exact conditions under which such adhesions occur, we have still much to learn. It is, however, admitted that scantiness of the amniotic fluid—that is to say, the condition known as oligo-hydramnios—is a predisposing factor. Gonorrhœal infection *in utero* is probably also a factor in some cases of amniotic adhesions (J. B. Hellier).

The outstanding anomaly for which amniotic adhesions seems best to account is coloboma of the eyelids. Dor and Nicolin (*Revue Générale d'Ophtalmologie*, December 31st, 1888) trace coloboma to an interference with the development of the eyelids by imperfect closure of the oblique facial fissure. On the other hand, in recent times more particularly, Van Duyse thinks the malformation to be closely connected with the presence of amniotic bands. Van Duyse's theory, as pointed out by J. H. Parsons (*The Pathology of the Eye*, Vol. III., Part I., p. 778), explains not only the coloboma, but also the cutaneous ridges and dermoids as persistent portions of the constricting bands. Dor's objection, that amniotic adhesions cannot account for the existence of bilateral and symmetrical colobomata (*loco citato*, p. 532), is met by the observations of V. Bruns, Pollailon, and Lannelongue, who observed such bands inserted into the middle of the cornea and passing symmetrically over the eyelids.

Coloboma of the eyelids is far from common, as may be inferred from the fact that Nicolin, writing in the year 1888 (*Thèse de Lyon*, 1888), was able to bring together 46 cases only from the collective literature.

Coloboma may range as regards degree from a tiny notch in the free border of the eyelid to a wide gap extending through the entire structure and exposing the cornea. The cilia are nearly always absent from the hiatus. In about 50 per cent. of the cases one eyelid is alone affected, and the upper is the seat of election. For example, among 90 cases of coloboma collected from literature for the purposes of this lecture, in 46 one eyelid was alone involved—that is, the upper in 36 and the lower in 10 instances. The collection included only two cases—namely, those by Lannelongue and by Morian respectively—where all four lids were implicated. Morian's case is suggestive, since the colobomata were associated with amniotic strangulations of the patient's fingers and toes, in addition to oblique facial clefts healed *in utero*. In some of the cases the coloboma was connected by a cutaneous fold with the eyeball, and in many others a dermoid growth existed in such a position on the eyeball as to fill more or less completely the gap left by the coloboma when the lids were closed. At the same time it cannot be denied that these defects in the lid, especially when large, predispose to ulceration of the cornea, as in cases reported by Conradi (1888), Cowell (1891), Juler (1892), and myself (1906). Hence, besides the deformity often caused by the coloboma, we have another and a very good reason for closing the gap in the lid as early as may be. In this connection it may be stated that 16 of the 90 patients included in my series had been treated surgically.

It is worth mentioning that in only six of the ninety cases of coloboma of the lid no associated deformities of the eye or of other parts of the body were alluded to in the authors' descriptions (Talko, Gillette, Despagnet, Major, Galezowski, and Creutz). Details, however, were often scanty. Curious tufts of hair arising from the eyebrow and directed towards the coloboma have been reported by Nuel, Frost, Morian, and Ohse. In Manz's case (V. Graefe's *Arch. f. Ophthalmologie*) of coloboma of the median part of each upper lid, the middle third of each eyebrow was absent. Notched orbits or deficiencies of the eyebrow have been reported by Nuel, Hassalmann, Schanz, and

Geissmar. Cicatrices, representing Nature's attempt at cure, have been noted by Snell (*Trans. Ophthalmological Society*, Vol. 1884, p. 348), Berry, and Rosa Ford (*Ophthalmoscope*, 1907), extending in the skin from the cleft towards the orbital margin. A similar line has been seen by E. T. Collins (*Trans. Ophthalmological Society*, Vol. XXV., 1905, p. 319) in the palpebral conjunctiva. The ocular complications of coloboma, in addition to those mentioned before, include epitarsus, pupillary membrane, coloboma of iris and choroid, adherent leucoma, notched optic disc, multiple or absent lacrymal puncta, and ectasia of the lacrymal sac. The general deformities most commonly noted in these cases have been deformed or supernumerary auricles, ill-developed malar prominences, macrostomia, post-anal dimple (so-called fovea sacralis), highly-arched palate, bifid tongue or uvula, stenosis of the nostril, absence of the external auditory meatus, hare-lip, cleft palate, and, lastly, oblique facial fissure or its remains.

It may be added, before passing from the subject, that cases have been described by Berry, E. T. Collins, Tyrrell, and Rosa Ford, where a small notch in the outer part of the lower lid, generally of both eyes, coincided with mal-development of the malar bone, as shown by flattening of the side of the face. The group, although not large, is important, inasmuch as the cases can be readily explained by the theory of amniotic adhesions.

(To be continued.)

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Sydney Stephenson, M.B.Edin., F.R.C.S., Ophthalmic Surgeon Evelina and North-Eastern Hospitals for Children, Kensington General Hospital, &c. Subject : "Congenital Anomalies of the Eye" (Part II.)*

ORIGINAL PAPERS.

THE DISEASES AND DISPLACEMENT OF THE TESTICLE IN CHILDHOOD. (a)

By D'ARCY POWER, F.R.C.S.Eng.,

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THE diseases of the testicle in children group themselves naturally under the headings of tubercle, syphilis, malignant growths, innocent tumours, and teratomata. The displacements are due to faulty processes of development carrying with them certain additional predispositions to disease and injury.

In opening a discussion on the subject the results of personal experience are given and questions are asked in regard to points which appear to stand in need of further elucidation.

TUBERCLE.

Most of the swollen testicles seen in the wards and out-patient rooms of a children's hospital are caused by tubercle or by syphilis, or, perhaps, speaking more correctly, by tubercle growing in tissues which have been prepared for infection by changes due to congenital syphilis. In private practice they are nearly always tuberculous without any admixture of syphilis.

Tuberculous disease of the testicle is rare in children, for Demme records 16 cases in 1932 tuberculous children, whilst Jullien only saw it 16 times in 5,516 children. But tuberculous inflammation of the testicle in children is much more common than these statistics show, and there is never a year in which two or three children do not come under my care for this form of disease. The inflammation is sometimes primary, but it is more often associated with other signs of tubercle, and there is frequently a definite history of injury. It is usual, therefore, for only one testicle to be affected. The diagnosis is easy, but the disease runs a somewhat different course in children from that which it follows in adults, because the gland is not functional in children.

When the infection is simple and the child is fairly healthy, the disease may remain localised to the affected gland. The swollen testicle is enlarged for a longer or shorter period, and then slowly diminishes. The inflammation disappears completely and the testicle may resume its original condition, or the process of involution may be carried beyond the normal, the testicle atrophies, and the child becomes monorchous. This, at least, is the statement generally made, but I should like to know if anyone has followed out the progress of a tuberculous testicle until it ended in atrophy. I have seen atrophy four years after an operation for the radical cure of a hernia in a child, and I have seen it after enlargement of the testicle due to congenital syphilis, but never as a result of tubercle.

The treatment of these cases of pure tuberculous infection may safely be palliative. Fresh air, cream, or cod liver oil, good food, and plenty of sleep, with a light suspensory bandage, are sufficient. But a jealous eye should be kept upon the child, and he should be weighed at frequent intervals. If the weight falls a careful and systematic examination should be made to ascertain whether there is any evidence of dissemination; the lymphatic glands, the bones, more especially the vertebræ, the peritoneum, the pleuræ, and the meninges of the brain are the most likely parts to become affected. The testicle should be removed at once when there is even a suspicion of such an infection.

The prognosis is not so good when the infection consists of a mixed culture of tubercle bacilli and pyogenic organisms. In such cases an abscess is soon formed, and the neighbouring lymphatic glands quickly become affected.

I would, therefore, counsel early removal of the testicle when suppuration occurs, because I do not believe that any good follows such partial operations as the scraping or excision of the softened parts of the testicle, but rather harm, for I have often seen these cases associated with tuberculous dactylitis, spinal caries, and tuberculous peritonitis.

SYPHILITIC INFLAMMATION.

Syphilitic inflammation of the testicle occurs at all ages from birth up to four and twenty, though it is most common before the age of three years. Both testicles are affected, and often at the same time. A hydrocele of the tunica vaginalis is an almost constant accompaniment, whereas in a tuberculous testicle a hydrocele does not occur in more than a third of the cases. The patient, if he be an infant, always presents evidence of inherited syphilis, often in a severe form. The testicles are extremely hard, and the beneficial effects of administering gray powder are so marked as to leave no doubt about the diagnosis.

The inflammation is usually diffuse, and leads to a general enlargement of the body of the testicle, but it is occasionally gummatous, in which case the outline is irregular. The epididymis may be affected, but it is much more usual for the tunica vaginalis to be involved in the inflammation, a feature which accounts for the frequent co-existence of a hydrocele. It is rare for suppuration to take place in syphilitic inflammation of the testicle so long as it is free from tuberculous infection; but it is quite common for the two infections to co-exist in the miserably marasmic children who are the subjects of these swollen testicles. The condition is so painless and chronic that it is often overlooked, and children are occasionally brought for advice in whom the process has continued for so long that cicatricial contraction of the inflammatory fibrous tissue has occurred and the testicle is atrophied.

I should like to know in connection with syphilitic inflammation whether any observations have been made as to the retardation of puberty which takes place as a result of inherited syphilis. I believe it to be part of a general failure of development and that it is not a mere consequence of the atrophy of the testicles, or of the ovaries, for the delay occurs in both sexes. It is certain that the patient is impotent as well as sterile when both testicles are wasted owing to inflammation due to inherited syphilis.

(a) **Abstract of Paper read in the Section for Diseases of Children of the British Medical Association Meeting at Exeter, August 1907.**

Teratomata.

Teratomata of the testicle are always cystic, for they are either dermoids or sebaceous tumours. Dr. Hilton, of Nebraska, collected the records of 79 cases. In these the teratoma was testicular in origin in 40 patients and scrotal in 21; in 14 cases it was situated in the inguinal canal and in one case it was derived from the tunica vaginalis.

These tumours form an interesting group and open up many points for discussion, as well as for elucidation by more careful examination. It is not yet known, for instance, whether a dermoid of the testicle is, or is not, a true tumour of the testicle itself. Indeed, the ease with which it can sometimes be dissected away from the gland makes it highly probable that in many instances a dermoid is in reality a teratoma, using the term in the sense of a parasitic fœtus. It is highly desirable, therefore, to determine, as far as possible, in each case whether the dermoid is within the tunica albuginea; whether it merely lies in the connective tissue between the tunica vaginalis and the testicle, or whether it is clearly attached to the scrotum, and, if so, whether the attachment is due to its being the place of origin of the tumour or the result of inflammatory changes between the scrotum and the wall of the dermoid. A section through the wall of the dermoid may show the presence of atrophied seminiferous tubules if the tumour has been developed within the substance of the testicle.

Dermoids are so rare that an error of diagnosis is pardonable, and it seems that they are most likely to be mistaken for epiploceles and for hydroceles of the cord. They are distinguishable from hydroceles by the absence of that translucency which is invariable in infants, and from omental hernia by the fact that teratomata are more uniform in outline, whilst the careful examination of an epiplocele will often reveal the presence of nodules. Complete reduction is no more possible in the case of a teratoma than in that of an encysted hydrocele, but in both cases it may be possible to push the tumour out of sight through the external abdominal ring.

There is no question as to treatment. The swelling in the scrotum should be explored, and the dermoid removed without sacrificing the testicle, if possible, but if it be actually incorporated with the gland the whole organ must be removed, as there is a definite liability to inflammation, suppuration, or hæmorrhage after slight injuries. It would be interesting to learn if any one has yet seen teratomata affecting both testicles—for teratomata of both ovaries are not very rare.

Malignant Disease.

Sarcoma of the testicle occurs in boys æt. 10 and upwards, and, like sarcomata elsewhere they follow directly upon an injury in a considerable proportion of cases. The tumour primarily involves the epididymis, and the body of the testicle is less frequently involved at first. But the growth often runs a very rapid course, and much time is usually lost because it is painless and there is early loss of testicular sensation. The patient therefore does not apply for relief until the tumour has attained a sufficient size to make it inconvenient by its weight. The tumour is then found to be smooth, heavy, and hard, but its shape and even its very existence may be masked by the presence of a hydrocele or a hæmatocele. The affection is most likely to be mistaken for a thick-walled hydrocele, for tubercle, or for syphilis, but the rapid growth of a sarcomatous testicle soon indicates its real character.

I believe the prognosis of sarcoma of the testicle to be worse in boys and young men than it is in old people, for all the cases I have seen have ended fatally, even when an early operation has been performed. A misleading feature about the patients is that they remain in singularly good health for a long time, and it is difficult, therefore, to persuade either them or their friends that they are suffering from a deadly disease. Too much stress in these cases must not be laid upon the existence of enlarged lumbar glands, because, although they are often affected, I have seen more than one case in which there was diffuse sarcomatous infiltration of the whole peritoneum spreading from the epididymis up the spermatic cord without any infiltration of the lymphatic glands.

Mr. Eve (*Trans. Path. Soc.*, Vol. 38, p. 201) and Mr. A. G. R. Foulerton (the *Archives of the Middlesex Hospital*, Vol. 5, p. 234, and the *Lancet*, 1905, Vol. II., p. 1827) have shown the need for reconsidering the whole question of those tumours of the testicle which are usually called sarcomatous. Many of the tumours are really columnar-celled carcinomata beginning in the tubules of the rete testis or in the vasa efferentia. It would be interesting, therefore, to know whether, in the light of Mr. Foulerton's work there is any difference in the course and dissemination run by malignant tumours of the testicle when the deep lumbar glands remain unaffected and when they become early affected. I think it will be found that there are two classes, and that the patients in whom the lumbar glands are unaffected die sooner than those in whom they are early enlarged.

Imperfectly descended Testicle.

The questions connected with imperfect descent of the testicle open up such wide fields for discussion that it would easily form material for an entire debate. I shall, therefore, endeavour to narrow it down to a few practical points. Brushing aside all theory, I should like to ask, what is the general feeling about orchidopexy or the freeing of a testicle, which is imperfectly descended, with subsequent fixation to the bottom of the scrotum, the pillars of the external abdominal ring being afterwards sutured to prevent the testicle from re-entering the inguinal canal? I have done the operation many times, but, except in the very simplest cases, I have never satisfied myself that it was advantageous, and in a few cases the result has appeared to be so unsatisfactory that I have afterwards removed the testicle.

I think, therefore, that it is better to advise removal of the testicle in nearly all cases where it is imperfectly descended and can be felt, especially if there is evidence of a hernia and the abnormality is limited to one side.

When a hernia is present the sooner the operation is done the better after the patient has attained the age of four or five years. When there is no hernia, or only a small bubonocele, I generally advise the parents to wait until the child is seven or eight years old in the hope that the testicle may descend further into the scrotum. But I do not think it is worth while waiting until puberty, because a fairly accurate prognosis can be arrived at much earlier if the child is seen a few times at intervals of two or three months.

I have lately had two cases of acute torsion of the spermatic cord under my care, and in both cases the testicle was imperfectly descended. I contented myself in the first case with untwisting the cord, and was rewarded for my forbearance, but in the other case the testicle was removed, and the ring sewn up.

But the really difficult cases of imperfectly descended testicle are those in which the only son of influential persons is brought for advice at the age of five with both testicles lying within the inguinal canal close to the external abdominal ring. I see my way clearly when only one testicle is imperfectly descended, when the imperfect descent is associated with a hernia, as is the case in about 80 per cent., and when pain or symptoms of torsion have appeared. I know also what to advise when both testicles are situated comfortably in the abdominal cavity; but I confess that I am doubtful as to the best course to pursue when both testicles are situated within the inguinal canal at a point where they may be readily injured in the ordinary course of school life. They ought not to be removed, especially if large interests are at stake, and I therefore suggest that the wisest advice is either to leave them alone until they become troublesome, or else to put them straight back into the abdominal cavity. But if the latter course be adopted, the operation should be done early, as there is evidence to show that testicles thus replaced after puberty do not undergo development, whilst if they be replaced earlier the testicle may produce spermatozoa a few years between eighteen and twenty-five. It is then possible that the testicles may become functional, at any rate for a short time, though too much must not be promised to the parents. All that one can say is, that the boy will not then present the characters of a eunuch, and that he has been put into the best possible condition, under the circumstances, for the subsequent procreation of children.

An ectopic testicle must be treated on its merits. When it lies in the perineum, the gland may easily be put into the scrotum, for it is often attached to the tuber ischii, to the external sphincter of the anus, or to the skin by a single band of fibres which can be made tense. The subcutaneous division of this band sometimes allows of the testicle being replaced in its proper position, or, if this fails, an open operation may be performed, and the testicle can then be put into the scrotum. But when the testicle lies in the groin or in the femoral region, I do not hesitate to remove it, first, because testicles so placed are said to be always functionless, and, secondly, because they are more especially liable to injury.

HYDROCELE.

Of all the tumours in the scrotum of children, I think that an ordinary hydrocele is the most often overlooked or misinterpreted. Everyone is alive to the fact that children suffer from hernia, but students and practitioners alike seem to forget that hydrocele is nearly as common in infants as it is in adults. Children are, therefore, constantly brought to the surgeon with a diagnosis of rupture when a little care in examination would have shown that the swelling was in reality a hydrocele. The mistake is not very excusable in a case of hydrocele of the tunica vaginalis, though it is venial if the swelling be limited to the cord, especially if it be situated at or near the inguinal canal. The error in diagnosis is unimportant if a woollen truss be ordered, but serious harm may be done if determined attempts are made to replace the swelling within the abdomen, or if it be treated as a strangulated hernia, because from other causes the child has become constipated. In my own case I base the diagnosis very largely upon the sense of touch. A hydrocele always appears to me to be much more tense and elastic than any hernia I have ever felt. I am careful to place no reliance upon the translucency of the tumour, because I know that in young children the walls of the bowel are so thin as to transmit light quite easily. I know, too, that in babies a hydrocele is not so often pear-shaped as it is in adults. It may be so tense and well defined round the testicles that it moves quite easily in the scrotum, and it is often taken, therefore, for an enlarged testicle. Treatment, I think, should consist in simple puncture, but if the hydrocele refills there need be no hesitation in performing a radical operation even in very small babies, the operation being carried out on the same lines as in adults.

MEDICAL SUPERVISION OF SECONDARY SCHOOLS IN SWEDEN. (a)

By Dr. MED. GOTTFRID TÖRNELL.

To a certain extent Sweden may claim to be regarded as a pioneer country in respect of the appointment of medical officers in conjunction with the State schools. Mention is made of such officers as long ago as between 1830 and 1840, and in 1863 there was issued an ordinance prescribing the duties they were required to fulfil. It is fair to assume that as early as 1868 all the public schools in the kingdom had medical officers attached to their staffs. The school Codes of 1878 and 1892 contained paragraphs which still further extended the sphere of activity in the school allotted to the medical officer. The Code at present in force bears date February 18th, 1905. It contains detailed prescriptions concerning the duties of school medical officers, drawn up entirely in accordance with modern hygienic principles.

The work which is considered in this country (Sweden) to come within the purview of a school medical officer may be summarised under the following headings:—

1. To examine the scholars medically, in order to find out the state of health of each.
2. To adopt preventive measures against the spread of infectious complaints.
3. To superintend the school premises as regards their sanitary condition.
4. To provide against the scholars being overburdened with lessons, etc., and thereby becoming overworked.
5. To attend indigent children in case of illness, free of charge; and
6. To draw up statements upon any problem that may arise regarding school hygiene, and to hand in periodical reports of the work that it has fallen to their lot to discharge.

It is in accordance with the principles above stated that the "Instructions to School Medical Officers," issued as one section of the new Code of 1905, have been formulated.

The State Secondary Schools Supervisory Board has at its disposal the services of an expert in hygiene, and he is consulted on matters belonging to that aspect of education.

On the staff of every school there shall be a medical officer—appointed and remunerated by the State—whose duties are:—

1. To examine candidates for entrance to the school free of charge, if they are in indigent circumstances.

[In order to obtain entrance into a State secondary school, a candidate must be furnished with certificates to show: That he or she has been vaccinated, and that he or she is not a sufferer from any illness or defect which would render him or her unfitted to take part in school work, or which might exercise a deleterious influence on his or her schoolfellows.]

2. At the beginning of every term, in the presence of the teacher of gymnastics, to carry out a careful investigation of each one of the pupils, and to hand in to the headmaster or the class superintendent a report upon the result of such investigation. The pupils' sight and hearing are to be tested once every year.

3. To conduct a medical examination of any pupil, either at the suggestion of the headmaster or otherwise, whenever his or her state of health seems to require it.

4. To afford the headmaster any advice that may be necessary or expedient in case of an outbreak in the school of any infectious complaint, and to take measures to prevent the spread of the infection. A definite period of absence from school in the case of pupils having caught some infectious complaint, varying with the nature of the disease, is not prescribed by the school Code. In no case, however, is it permissible for a pupil who has had any such illness to return to school until the school medical officer shall have pronounced him or her free from infection, and have drawn up a certificate to that effect.

5. To attend indigent children free of charge. This article does not now appear in the school Code; it has long been in force with reference to Swedish public schools.

6. To inspect all the school buildings thoroughly, and to be present at the teaching of gymnastics at least once a month. In regard to the latter duty, attention should be particularly directed to seeing that the pupils are not set to execute movements or do exercises which are unsuited to their physical powers.

7. To spend at least one hour per week on the school premises, for the purpose of affording advice, if such be needed, to the headmaster, the other masters, or the pupils. This hour of attendance is to be employed partly for the reception of any member of the school community who desires to consult a medical man, and partly for the inspection of the conditions under which

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(a) Read before the International Congress on School Hygiene, London, July, 1907.

the pupils do their work; how they are seated as regards light and air, etc., how they sit at their desks, the posture of their bodies, etc., and what degree of mental alertness they display at their lessons, etc., etc.

8. To supervise the curriculum of work. The chief point for the medical officer to observe here is whether work and leisure are suitably apportioned in the curriculum, so as to avoid the occurrence of overstrain among the pupils. If the medical officer finds cause to disapprove of the curriculum in any particular, he should bring the fact to the notice of the headmaster.

9. To hand in annual reports upon duties performed by virtue of office.

10. When new buildings are being erected or old ones altered or repaired, to make sure, provided no other specialist in hygienic matters is called in, that the requirements of hygiene are being duly and adequately fulfilled in the building work as it proceeds.

11. To be present at any meetings of the staff of the school where questions pertaining to the health of the pupils or the sanitary arrangements on the school premises are being debated; to take active part on such occasions not only in the discussion, but likewise in the voting or drawing up of the resolution of the meeting.

[Thus, as far as hygienic matters are concerned, the school medical officer is not merely an advisory member of the staff; he is also empowered to assist in the framing of decisions.]

The school medical officer has furthermore to do what in him lies to see that the regulations laid down respecting physical education and the sanitary arrangements at the school are duly observed and carried out.

These regulations are, briefly, as follows:—

(*a*) The schoolhouse should be in a healthy situation, with plenty of space near it for outdoor games; a so-termed play-shed for resting, sheltering or hanging clothes in should be erected on the outskirts of the playground.

(*b*) The rooms intended for teaching in, etc., are to be constructed in accordance with regulations issued specially in regard to them.

(*c*) The gymnasium must be provided with a changing-room, a douche and a bath-room conveniently near at hand.

(*d*) Opportunities should be provided during the summer for the pupils to receive instruction in swimming.

(*e*) With reference to the heating, ventilating, lighting and cleaning of the various rooms, lobbies, etc., in the school buildings, the headmaster shall draw up, in consultation with the school medical officer, a detailed plan of procedure, to be scrupulously followed out by those whom it concerns. A copy of that plan of procedure should be nailed up on the wall in some suitable place in the school building.

(*f*) To each pupil there should be allotted about 6 cubic metres of space and 1¼ square metres of floor area. The pupils' desks should vary in size to accommodate scholars of different heights. Short-sighted and deaf pupils are to have suitable places assigned to them by the school medical officer.

(*g*) Text-books, etc., are to be printed in a type which is sufficiently large and clear to preclude any danger of the sight of the pupils being injured by the use of them.

The school medical officer is not required under the present Code to do any teaching work.

Any qualified doctor may apply for and obtain the appointment of school medical officer. It has not been considered essential that he should have gone through a special course in school hygiene, inasmuch as instruction in hygiene forms part of the course of study which all medical students take up when preparing for their qualifying degree.

What the effect of the new Code will be as regards the health of the school children it is as yet difficult to determine, for only a brief period of time has elapsed since it became law. If it is fair to judge, however, from the results already observed, and, above all, from the exceedingly cordial co-operation that prevails between the teachers and the medical officers at the schools, there is every reason to believe that the new Code will work very beneficially in the interests of the generation now attending school.

THE BEGINNINGS OF DISEASE—THE PASSAGE FROM HEALTH TO DISEASE.

By J. LIONEL TAYLER, M.R.C.S., L.R.C.P., Lond.

It seems probable—though no figures worth quoting are available, as there is no general registration of disease—that quite 30 per cent. of the general practitioner's patients could be classed under the above heading as being midway between the state of health and that of disease; and, as far the greater proportion of all illnesses are seen by the ordinary medical man, this means that from 20 to 25 per cent. of all practice is concerned with such phenomena.

I am purposely excluding from this article the beginnings of specific diseases, for these can be more appropriately considered by themselves in reference to certain more or less obvious, possible channels of infection by which specific germs can gain access to the organism. The question of simple impairment of health can thus be studied by itself, and as this constitutional failure accounts for the presence of at least three or four patients out of every ten in the ordinary doctor's waiting-rooms and for nearly a like proportion of cases on his visiting lists, it is surely profitable to give the matter some attention.

There are many popular designations for this condition of which "run down," "out of form," "seedy," "below par," "off colour," are examples, and such a phrase on a patient's lips calls up to the medical man's mind a definite, or rather very indefinite, group of related symptoms. For this state the general practitioner uses one word—debility—more frequently than any other, and he recognises a chronic as well as a temporary form, and often refers, when granting medical certificates, in writing to them. It would, however, be more accurate if patients suffering in this way were divided into three instead of two groups. The first, to be restricted to those individuals whose breakdown is slight, and the subsequent convalescence, complete and relatively permanent; the second, to those who recover much of their original health but tend to breakdown again at frequent intervals, the recurrent cases; and the third, those who seem to have acquired a chronic ailing habit and are never, or very seldom, free from a weary tired feeling and general malaise.

It has, however, to be borne in mind that an even earlier condition exists which medical men are very seldom indeed consulted about, namely, those slight failures in health that last for a few hours, and only come to our notice when they repeat themselves sufficiently frequently so as to be an annoyance to the patient. Chemists, however, often have customers drop in for a dose of "tonic" or a "pick-me-up," and though in many cases such people are only feeling the reaction of unhealthy excesses of the day before, yet there are others in whom this feeling marks the first onset of a failing constitution. Hence we may speak of these "low," "done up," "limp" feelings as symptoms of the earliest form of divergence from health, and therefore these occasional or recurrent indispositions are intermediary stages, shading more and more deeply by insensible gradations from health towards debility and disease.

The importance of these phenomena has never been sufficiently appreciated. Their prevalence is so common and widespread over the whole population that no single individual, however healthy, entirely escapes, and the inconvenience that is caused is manifest, so that the need for good treatment is great, while their scientific value is not less obvious, as the practitioner is presented with the most generalised pathological data that exist. Disease is thus seen in its embryonic state, and its development from this point to definite recognizable disorders should be clearly traceable.

The symptoms are legion, and the diagnosis is always arrived at by a process of exclusion, for on examination organic disease is found to be absent. The central factor, however, that meets one, from whatever point of view the symptoms are studied, is that of lassitude, weakness and flaccidity. The flabby, pendulant character of the voluntary muscles, when placed in a relaxed position, is obvious to the eye and touch. The collapsible condition of the smaller arteries is shown by the passive modifications in circulation that posture makes—defective peristalsis by constipation, flatulence, and occasional diarrhœa. In a woman, often menstrual irregularities disclose a weakened uterine wall. The skin is deficient in elasticity, is readily marked by any external body, and the impression thus made disappears slowly. Everywhere there is evidence of lack of tone. There may be nervous irritability or apathy, excitability or depression, but the one common complaint of patients is, "I can't settle to anything." Boils or small spots are quite common, and a loud throat cough, with thick relaxed voice and slightly reddened congested throat, are often noticeable. In nearly all people there is some increase of pallor, due possibly to a defective blood condition, and in some a muddy, putty-like complexion, with a damp, cold skin, are typical associations. In extreme cases the whole appearance is strikingly feeble, drooping shoulders and stooping figure, and a resigned, effortless, beaten expression of face.

The causes of this disordered functioning are multiform—overwork, unsuitable vocation, bad housing, monotony of life, dissipation, self-indulgence, sexual excess and abuse, laziness—anything, in fact, that impairs by excess of use or from too little exercise the tone of the body and mind.

Advice differs according to the cause. For the overworked, rest; for the underworked, activity; for the dissipated, restraint, but tonic treatment and change are rightly prescribed to all. In the vast majority of instances the patient benefits surprisingly, and a few weeks are sufficient to produce a nearly complete recovery. But there are, as we have seen, recurrent and chronic cases, and in these the disability once established tends to pass into a permanent neurasthenic condition, and it is then, when it is really too late, that the specialist is often called in, and he may fail to realise that the patient has been getting weaker and weaker for many years, treated first by some local chemist, later perhaps by some quack, later still by a local practitioner, till at the last, as a forlorn hope, a mental expert is consulted. Many of the poorer struggle on, especially those who are overworked, without treatment, because their living depends on their daily attendance at their employment. And, because no disease can be specified so that leave for convalescence might be granted, they drag out a weary existence till a final breakdown occurs. Sometimes this termination ends in insanity; sometimes a shiftless feeble character is produced; sometimes an acute illness, such as rheumatic fever or influenza, may still further cripple or afford the necessary opportunity for rest and recuperation; but from any point of view, I am convinced that more care is needed than is ordinarily given to such patients.

There are many interesting questions that this study of indisposition and debility raises. I think it will be generally admitted that the presence of excess of toxic material in the blood and tissues is one of the principal factors in the situation. This is shown by the similarity of this debilitated state to the prodromal stages of ascertained infectious and contagious diseases, and also by the happy results that follow suitable exercise, rest, simple dietary, and mild elimination treatment. But the aspect that should be of greatest importance to the scientific and practical medical man is the relation of the particular constitutional bias of the individual patient to the individual peculiarities of the symptoms that appear. For while weakness is complained of by all, no two cases are identical.

One mentions headache; another neuralgia; another sleeplessness; another sharp twinges and stiffness in the muscles and the joints; yet others allude to backache; difficulty in breathing and a sense of suffocation; persistent nausea at the sight of food, and so on. In not a single instance, if care be taken in obtaining particulars, will it be found that general debility, always the principal symptom, is the only one; for local disturbances varying with the patient are also present, and the same local phenomena tend to reappear in the same person. To the scientific practitioner, therefore, these minor differences afford clues, *if the same individual symptoms are evident in more than one attack*, of a probable natural constitutional predisposition to disease in the direction of the distinctive symptoms. And were careful records kept, I believe it would be found, in the majority of instances, that later specific diseases tend to follow the line of susceptibility thus revealed. If this be so, methodically compiled medical notes of patients would enable us to trace more accurately the beginnings of disease and treat it more scientifically, in addition to being able to warn patients how to avoid what is thus early threatened.

But apart from this, the individual treatment of debility leads at once to more favourable results. For while the major symptom is always in some degree benefited by tonics, yet the minor ones, differing in each case, are often sufficiently important to check recovery. Sleeplessness, for instance, is often due to flatulent distention of the bowel, and when the tonic, alone or even continued with a hypnotic, fails, the simple addition of a harmless carminative, like ginger or peppermint, perhaps combined with carbonate of soda, will often give very favourable results. In like manner pain in the back, which is neither of ovarian nor of dyspeptic origin, will disappear by the use of citrates, and with it a depression that had before persisted, showing, though no albumen be present in the urine, that the kidneys had been unable to eliminate toxic substances from the blood. Similarly, a feeling of suffocation will give way at once to better ventilation or to a change to the seaside.

One other consideration is worth dwelling upon. Is the debilitated individual exposed to greater immediate risks by the mere fact of his or her debilitated state? It is not easy to answer this question positively, but it seems likely that, as in tubercular diseases, debility is now an accepted predisposing cause. It is extremely likely to be so in others, but how far it is a small or large factor has yet to be determined.

A good deal might be written on the variable physiognomy that patients present: the careworn appearance of the overworked, the soft, round fatness of form of many who owe their trouble to wealth and inactivity, and the lined, baggy look of the dissipated. But, through all, as I have mentioned, runs the one common feebleness that relates them.

To summarise, probably at least one-third of medical practice is concerned with minor departures from health. Both from the widespread inconvenience that such indispositions give rise to, and from their scientific value, as the starting-points of disease, such borderland phenomena are well worthy of attention. There is here a field for investigation that is a wide and important one, and it is for the general practitioner to cultivate it and bring its richness into the common medical harvest.

THE EARLY DIAGNOSIS AND TREATMENT OF PROGRESSIVE PARALYSIS.

By KARL HEILBRONNER, M.D.,
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If in the case of progressive paralysis, which, as experience shows, with all its oscillations and varieties of course leads eventually to death, we may not expect actual recovery, the physician can still by timely interference do much good in the early stages; and, on the other hand, by failing to recognise the disease, the consequences of his sin may be very serious. Very frequently, however, the disease may not be recognised, or it may be recognised too late. The non-recognition of the very earliest stages depends on the very gradual and insidious development of the disease, so that even to the experienced the symptoms become distinct only after a time. But even after this point of time the diagnosis that might be made is not made, partly from want of familiarity with the features of the disease, and partly because the physician really " does not think."

But the designation of the disease, " dementia paralytica," or " progressive paralysis," shows the nature of it—a disease running a progradient course and characterised by dementia and paralytic symptoms, that even, if often, interrupted by remissions frequently lead to death after a few months, but mostly after a few years. Though mainly a disease of the " best years," it attacks men more frequently than women. It only appears on a foundation of syphilis, and its anatomical substratum is a diffuse atrophy in all parts of the central nervous system in varying participation, but without any gross macroscopic lesion.

Dementia and paralytic phenomena are the indispensable symptoms of the disease; but they do not yet justify a diagnosis of paralysis, as other processes also may give rise to the combination, such as typical multiple sclerosis, cerebral tumour, idiocy with paralysis and convulsions, post apoplectic dementia of the aged, intoxication (saturnism, bromism, uræmia, alcoholism), injuries, cysticercus of the brain, a typical multiple sclerosis, many diffuse meningeal tumours, syphilitic meningitides, pachymeningitis. There are also combinations of tabes with diminished psychical activity, which at least practically require a different valuation from the average of paralyses on account of the very slight tendency to progression.

Moreover, in the early stages of the disease by dementia, one must not think of gross insanity. The intellectual failure is of a much slighter grade, and just as little by paralysis does one mean complete paralysis in the usually accepted sense, but rather a more delicate disturbance of innervation.

If the paralysis runs its course purely under the symptoms described, so there is the pure demential form. To this may be associated still other symptoms of any other psychoses (anomalies of affection, delusions, hallucinations). In numerous cases the paralysis runs a purely demential course.

We can divide the somatic symptoms into cerebral and spinal, the latter again into lateral (spastic) and posterior (tabetic).

The symptoms connected with the lateral cœnurus (exaggerated reflexes, hypertonicity, or pareses), especially at the commencement, are not behind those connected with the posterior column in frequency. They must be appraised with caution, however. Simple exaggeration of the patellar reflex is met with in the healthy and in functional disorders. A symmetrical exaggeration is at the most to be taken into account, along with other very suspicious symptoms. The same may be said of the pseudo-clonus that soon passes off and does not always make its appearance, whilst the prolonged ankle clonus, that increases in intensity, and that patellar clonus produced by pushing the patella downwards are characteristic symptoms. Babinski's reflex is also in the latter category, *i.e.*, the typical slow dorsal flexion of the great toe with extension or flat-position of the remaining toes.

The symptoms referable to the posterior column, the tabetic, may be properly divided into two groups. In one the tabes long precedes the other symptoms, and is quickly recognised. More frequently the posterior column symptoms develope only just before the paralytic ones or simultaneously with them. Its symptoms, therefore, do not strike the eye as in old tabelics, but they must be looked for. Testing of sensibility gives with tolerable frequency a " hypalgesia," partly purely of psychical origin, and generally very widely spread; the ataxy is rarely extreme. Romberg's sign (swaying when the eyes are closed and the feet placed together) fails with striking frequency. The attention is to be principally directed to (*a*) The absence of the patellar reflex. Proof of this is difficult in people wanting in intelligence from their straining. One should be careful not to conclude that the reflex is absent when involuntary contraction of the quadriceps prevents its taking place. The attention of the patient must be drawn away from the examination, as his personality increases during it, and he should be asked rather abruptly how he gets on with—his mother-in-law. Simple lessening of the patellar reflex is of importance only when unilateral diminution is constant on one side. The absence of the reflex of the tendo Achillis is less markedly shown, but it is a warning to be cautious, especially if unilateral. (*b*) Pupillary changes. By far the most important disturbance is reflex rigidity (failure to contract on light). It justifies the strongest suspicion of locomotor ataxy or paralysis. Absolute rigidity is more frequently a consequence of syphilis, exceptionally also of trauma or alcoholism. Slow reaction to light is also to be looked upon seriously. Pupillary differences are also frequent in paralysis, but as they are frequent under very various conditions, they are not, when unattended, of much diagnostic value. Pupillary rigidity and loss of the patellar reflex always, therefore, call to mind paralysis or tabes; but it is not by any means the case that every paralytic shows them, and still less every commencing paralytic. (*c*) Hypotone (increased passive movement, especially of the lower extremities) in its lesser degrees is only demonstrable in patients who can easily exclude their voluntary movements. Its value is much increased when associated with considerable increase of the reflexes, or other symptoms of disease of the lateral columns. The cerebral symptoms are in part general (headache, sense of pressure, etc). These have no specific character. For the rest they may be looked upon as expressions of disturbance of definite, cortical, mostly motor lesions. They appear in part insidiously, in part in distinct attacks.

Amongst the first, a change of expression is often a very early sign; without any proper paresis there is a flabbiness and emptiness of the features, which is not fully explainable by dementia. Nearly allied to this is exaggeration in mimicking and clumsiness in carrying out movements; a certain unreadiness in the arms and legs, not altogether explainable by the spinal symptoms, is frequently an early phenomenon. Further than this, paresis of the facial appear early, deviations of the tongue and tremors; but these from the frequency of their occurrence, especially in drinkers, are when alone not of much value.

Disturbances of speech are very early symptoms—symptoms in the strictest sense. Often there is only a certain slowness, often associated with absence of accent, or with it wrongly placed; in other cases the slight precision of innervation leads to mere chattering, to literal paraphrasing, dropping of letters and syllables, turning things over and repetitions, tripping over syllables; something like stammering also takes place.

Where all these component parts are found together, a diagnosis may be formed almost with certainty from the speech alone; but it must be borne in mind that an excited neurasthenic, and especially in presence of the doctor who is examining him, will at times talk queerly—" reel off," as it were. Some of the symptoms are shown off much better in conversation than in special testing, in which, moreover, the celebrated special test words can be well dispensed with, and are often bewildering.

The disturbances in writing correspond in their elements to those of speech, consisting partly in change of the form of the letters, tremor and wandering movements in consequence of motor defective innervation, and in part the same transposing and leaving out of letters as in speech. Only serious disturbances in writing are made evident in short "writing tests." Not infrequently for the rest the handwriting remains good for a very long time.

Amongst the most important of the early symptoms are the attacks of paralysis, as they are often the first occasion for calling in a medical man. But in spite of this, on account of the transient character of the symptoms, their importance is often under-valued. The customary grouping, even if it cannot be carried out in its entirety, distinguishes apoplectiform and epileptiform attacks. The first-named vary between the slightest grades (giddiness, mental confusion) and the severe attacks of loss of consciousness, with succeeding grave unilateral lesions. Serious conditions also that are of almost pathognomonic import as regards paralysis often recede, usually within a few days, leaving only inconsiderable remnants that correspond to the permanent cerebral condition.

The epileptiform attacks in the lightest form appear as localised Jacksonian spasms that leave behind paralysis and paresis. The severest attacks resemble those of genuine epilepsy. The attacks have a great tendency to recur, and even a state of grave status epilepticus is not uncommon.

The dementia of paralysis does not lead at first as such to formal disturbance. What strikes me frequently at first is a defect in the ethical relations, from a slight want of tact to a grosser offence against the proprieties. Neglect of externals, and in regard to clothing, belong to a similar category; further voracity, sudden exaggerated sexuality (often with diminished sexual power), the sudden giving way to alcoholic excess, tendency to sudden outbursts of anger, associated with indifference when more important interests are in danger, caprice, alternating with excessive positiveness.

The intellectual failure in its narrow sense shows itself as deficient comprehension, inability to fix the attention, forgetfulness, want of grasp, imperfect power of combination, inability to recognise familiar faces, defective acquaintance with the elementary details of their own profession. Wherever there is the slightest suspicion of commencing paralysis, cautious inquiry from those connected with the patient should never be delayed as to their normal condition.

Psychotic symptoms in the narrower sense are often absent at the early stage. The commencing paralytic at first does not give the impression of being mentally affected in the vulgar sense of insanity. The most frequent commencing signs are groundless fits of jealousy—an exaggerated sense of well-being, combined with a mania for planning and an impulse to activity, which lead to undertakings that, if carried out, would in an incredibly short time lead to beggary. A similar danger threatens the dementia paralytic through neglecting his business, and, above all, through lavish expenditure.

The graver paralytic psychoses (especially the classic maniacal paralysis) generally belong to later stages. The cases in which the paralysis comes on without specific paralytic prodromata, directly under symptoms of another psychosis, are rare exceptions; they occur more frequently in cases of old locomotor ataxy.

In spite of the review of the features here given, in individual cases the differential diagnosis between paralysis and neurasthenia cannot be made at once, as paralysis may occur in a neurasthenic just as it may in a healthy individual.

On the whole, however, the danger of a mistake is not so great, and the diagnosis of neurasthenia may be determined by exclusion on the basis of repeated careful examination, and after the exclusion of organic mischief. Those cases must be examined with special care—bearing in mind the close connection between syphilis and paralysis—in which a neurasthenic patient has previously been infected with syphilis.

As regards the diagnosis of paralysis as opposed to other organic diseases great caution is required, especially in the case of alcoholics, and further, in old ataxic cases, such a diagnosis can only be deemed certain when unobjectionable cerebral symptoms are present. The examining physician must take care not to speak of the danger of a serious psychosis in the presence of the patient; if the diagnosis is correct it does not do him the least good, if incorrect, incalculable mischief may have been done.

Treatment.—Considering the close connection with syphilis, the question of a course of mercurial treatment first comes up. It has in general proved useless; it is indicated only where specific changes cannot be altogether excluded, and thus in all cases where affection of individual basal nerves is present, small doses of iodides may be given for lengthened periods (sod. iodid 1.0 to 1.5 grm. pro die). From the disappearance of attacks, however, specific disease need not be concluded, as these attacks also disappear spontaneously. The bromides also in large doses, are not very effective in the stages of excitement. In case of sleeplessness prolonged baths at 35 deg. to 36 deg. (cent.) or hypnotics in doses not too small (veronal 0.5 to 0.6 grm. trional 1.0 to 1.5 grm.; paraldehyde 4. grm.; amylhydrates 4. to 5 grm. in a 10 per cent.

aqueous solution, or by enema), and the most prolonged rest in bed.

A special diet is not requisite. A glass of dinner wine, smoking, and the accustomed cup of coffee may be permitted without injury. On the other hand, " going out," from the danger of excesses, should be forbidden. Much more important is the further care for the patient. First of all, when the diagnosis is certain, the physician must draw the attention to those belonging to him to the seriousness of the condition, and with them see about his admission into some institution for seclusion. Such a course is, in almost all paralytics, as a protection, both to the patient (danger of suicide) and his family, absolutely indicated. Only the pure demented torpid forms may seem at first not to demand seclusion. In all cases business activity must be given up at once; a lengthened period of complete mental rest gives some prospect of temporary improvement; but the complete retirement from business best arrests the dangers that the patient, especially when he is in a responsible position, may prepare for himself or for others. Generally the pure demented paralytic adapts himself to the change of giving up business with great nonchalance—the nonchalance itself may afford a final criterion in the differential diagnosis. Business matters will be most safely kept away by putting the patient into an asylum, or some sanatorium for seclusion. Any special methods of treating the basal disease are not possible, even here, but a warning must be given against any energetic hydropathic or any similar procedures.

In the case of any undoubted paralytic who has means or credit, it is advisable to have a trustee appointed as soon as possible. The consequences of insane behaviour may be properly annulled by law, S. 1021, 2 B.G.B. (but this is, unfortunately, frequently not practicable). In answer to the question whether the patient's condition of mental disturbance covered the time when something improper was done, a specimen of the writing of the time in question may be useful.

Regarding the validity of a marriage contracted by a paralytic after the outbreak of the disease, the claims for nullity can be raised according to law, S. 1325, B.G.B. by the legal representative (S. 1336). In the frequent criminal processes against paralytics the application of S. 51 Str. G.B. may be claimed. Very frequently the commission of some illegal act will be the first indication of an onset of the disease. Paralytics are not properly liable to punishment in accordance with law S. 487, Str. Pr. O. If after any condemnation it appears probable, or only suspicious, that the act leading to the punishment was the commencement of a paralysis that only became evident afterwards, it may be desirable, in the interests of the family, to demand a fresh inquiry according to S. 399, 5 Str. P.O. The number of cases in which paralytics are condemned for wrong doings would diminish with increased knowledge and attention to the early stages of the disease.

OPERATING THEATRES.

KINGS' COLLEGE HOSPITAL.

"Hæmorrhagic Necrosis" of Cancellous Bone.—**Mr. Peyton Beale** operated on a man æt. about 35, who had been admitted with the following history: he was by trade a leather dresser, and beyond a few falls from a bicycle had suffered no previous illness or accident of any moment. About five weeks before, he began to complain of severe pain in the lumbar region; the pain was deep-seated and only relieved by the recumbent position; there was no evidence to show that it was in any way due to muscular rheumatism or to his urinary organs, or indeed to any other organs. The pain was soon succeeded by retention of urine followed by incontinence, due to the overflow of the distended bladder; in a few days this was followed by retention of fæces proved to be due to paralysis of the lower bowel; later on incontinence of fæces came on, clearly due to paralysis of the sphincters. He was losing flesh, but was able to walk about until the time of his admission. Upon admission he was found to have: 1. Anæsthesia corresponding to the cutaneous distribution of the left fourth sacral nerve; this anæsthesia extended in some degree down the back of the left thigh, probably corresponding to some cutaneous branches of the small sciatic nerve coming off from the third sacral. 2. Paralysis of the perineal muscles and sphincters and some paresis of the glutei, and perhaps of the hamstrings as well. Upon careful examination under an anæsthetic, a marked swelling of the left erector spinæ in the lumbar region was observed, and on inserting an exploring needle a very little blood-stained fluid was obtained, indicating that this swelling was probably due to œdema of the erector spinæ itself and of the tissues beneath. On examining the rectum a large fluid tumour was felt in front of the sacrum and extending upwards beyond the reach of the finger; this contained loose bodies thought to be pieces of bone, and the case was looked upon as probably one of advanced tuberculous caries of the lower lumber vertebræ involving the lumbo-sacral joint. It was decided to explore the sacrum by operation, and an incision about nine inches long was made over the spines of the lower lumbar vertebræ and back of the sacrum. On separating the muscles from these portions of bone and from part of the posterior aspect of the iliac bones, the whole of the exposed bone appeared dark grey in colour and denuded of periosteum; on cutting through the external shell of compact issue, practically the whole of the cancellous bone was found to be replaced by dark fluid and clotted blood; in many places there were several loose pieces of what appeared to be necrosed cancellous bone. On cutting through the posterior shell of the sacrum there appeared to be nothing left of that bone, and the cavity which had been felt *per rectum* was one containing blood and many pieces of cancellous bone. The membranes of the lower lumbar cord were exposed and incised, and a large quantity (about two ounces) of slightly blood-stained cerebro-spinal fluid escaped. The wound was then closed, a gauge drain having been inserted. Mr. Beale said that until further investigation had been carried out the case could only be described as one of hæmorrhagic necrosis of cancellous bone. The man's symptoms improved for three days after operation, the pain being very much relieved, but on the morning of the fourth day he died very suddenly. A post mortem was subsequently performed, and it was then found that every bit of cancellous bone in connection with the lower part of the spine and the pelvis exhibited the same characteristics as those exposed at the time of operation, viz., "hæmorrhagic necrosis." Professor Dalton, who conducted the post mortem examination, was of opinion that it was probably a case of very extensive myeloma. It may be mentioned that the man was found to have a tumour of the stomach close to the pylorus, which appeared to be a carcinoma, and also some enlarged cervical glands which looked like secondary carcinomatous glands.

Thirty-five cases of bubonic plague have occurred at San Francisco up to date, of which twenty have ended fatally. Twenty suspected cases are under observation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 22nd, 1907.

Diazo-reaction of Ehrlich in Eruptive Fevers.

To find the diazo-reaction one should proceed as follows: Pour into a test tube two and a half cubic centimetres of urine, to which is added an equal quantity of the following solution:—

Hydrochloric acid, 50 grammes.
Water, 200 ditto.
Sulphanilic acid (to saturation).

And then two drops of

Nitrate of soda, 0:50 centigrs.
Water, 100 grammes.

That done, the tube is agitated, and ten drops of ammonia are poured in slowly, when a red ring is seen to form at the point where the ammonia comes in contact with the rest of the liquid. After mixing, the red colour is communicated to the entire solution, while the froth resulting from the agitation is of a rose colour, and adheres to the walls of the tube. Such is the reaction in typical cases; that is to say, in eruptive fevers. In normal urine, when tested as above, the colour remains unchanged.

However, certain medical substances, as guaiacol, creosote, benzonaphtol, in being eliminated by the urine, can give a similar reaction. It has nevertheless a certain value for diagnosing such affections as tuberculosis, typhoid fever, and eruptive fevers.

In many cases of typhoid fever the reaction of Ehrlich revealed at the very beginning the nature of the affection, where a positive diagnosis was as yet impossible.

In measles the reaction rarely failed, and before the characteristic eruption had been observed. The colour seems to deepen as the fever increases, and becomes more clear as the temperature falls.

The duration of the reaction is five or six days on an average.

In scarlatina, the reaction is generally negative, as well as in diphtheria.

Sea-Water Treatment.

Injections of sea water, rendered isotonic by dilution with sterilized water, have entered into daily medical practice in France, and notably in Paris, where Dr. Quinton, one of the most ardent partisans of this treatment, has established a dispensary, largely attended by patients suffering from eczema, and children more or less emaciated by chronic gastro-enteritis or suffering from eczema. Chronic constipation has been also treated with success by the saline injections. The doses vary from one drachm to four ounces, and are repeated every two days. The region selected for the injections is generally the scapular, but the abdomen is sometimes preferred.

Apoplexy.

A patient has lost consciousness, the treatment differs according to the cause. Is it a case of coma due to uremia or to diabetes? The diagnosis is not always easy. The antecedents of the patient with signs of diabetes or nephritis that he might have presented, will clear up any doubt. Other affections might be pre-supposed, meningitis, hysteria, syphilis (in a young man), but if the diagnosis inclines to cerebral hemorrhage, the treatment varies with the condition of the patient. If he is pale, with rapid, weak, and irregular pulse, injections of camphorated oil or cafein, followed by a stimulating mixture, if the patient can swallow, constitutes the first treatment, while mustard is applied to the legs and thighs.

More frequently the practitioner will not have to prescribe this treatment, for instead of being pale with a weak pulse, the face of the patient will be congested, and the pulse will be strong and bounding. Here blood letting will be necessary, either directly or by means of ten or twelve leeches placed behind the ears, and the ice-bag placed to the head. A drastic purgative will be prescribed, or an enema, while mustard is applied to the legs.

The following days the purgatives will be continued and a blister applied to the back of the neck.

The consecutive paralysis will be treated towards the tenth day by movements in the articulations, and six weeks afterwards by electricity (galvanic currents).

The diet will be lacto-vegetarian, with suppression of all spirituous liquors. As to iodide of potassium, its action is problematic, and in any case it should be prescribed in only small doses.

GERMANY.

Berlin, Sept. 22nd, 1907.

At the Medizinische Gesellschaft, Hr. Graeffner showed a patient with

Ochronosis,

the first case that had ever been shown in the living. This affection, first described by Virchow, consisted in a brown colouration of the cartilages and skin, occasionally with black patches on the mucous membranes and cornea. Pick had propounded the theory that the affection was the result of chronic carbolic poisoning. In many cases the patients had suffered from chronic ulcers of the legs, and had been treated by dressings of carbolic acid. There were also cases with alkaptonuria in which carbolic acid did not play a part.

Hr. v. Hansemann mentioned a case in which carbolic acid certainly did not play a part. There must therefore be at least two kinds of ochronosis.

Hr. Pick made a distinction between endogenous and exogenous ochronosis. In the latter form carbolic acid was the cause of the pigmentary deposit.

Hr. Orth read a paper on

The Immunization of Guinea-pigs Against Tuberculosis.

He gave an account of his experiments for producing immunization against tuberculosis in guinea-pigs by means of the bacilli of turtle tuberculosis discovered by Friedmann. The animals were first infected with the bacilli of tuberculous turtles; they were then supposed to be in a position to resist tuberculosis from any other source, whether human or any other warm-blooded source.

An animal inoculated with turtle tuberculosis might become diseased, but recover and gain in weight. An animal was so treated, and a year and 12 days afterwards was killed. Tuberculous changes were found on the peritoneum; they had implicated the testicles in which were tuberculous nodules with giant cells; but no tubercle bacilli were discoverable, and even cultures remained sterile. In a second animal, however, into which some of this tuberculous mass was injected subcutaneously, in spite of it appearing well and increasing in weight, on being killed 10 months afterwards, tuberculous changes were found on the peritoneum, and a few baccili were found in the regionary and distant lymph glands which developed sparingly in cultures.

This showed that the bacilli of turtle tuberculosis really belonged to the group of tubercle bacilli; that they were not killed off in the guinea-pigs, but set up a slowly progressing tuberculous affection.

The other animals were infected with human and bovine tuberculosis. All the animals were therefore equally tuberculous, but those with the preparatory treatment lived somewhat longer than the control animals. The mistake was often made of killing the control animals too early. Tuberculosis required time, and results free from objection were only to be obtained if we waited until the animals died. He only killed some of the animals in order to study their condition after infection. In one of the animals that had undergone the preliminary infection, he found a general tuberculous eruption everywhere on the eighteenth day. He observed further that the animals with the preliminary treatment did not get the usual general infection, but only typical pulmonary phthisis with cavities, although they had not lived a long time. The cause of this cavity formation, therefore, did not lie in a lengthened life, but rather in the preliminary treatment.

As Baumgarten and Orth had previously pointed out, these experiments again showed that the lung disease commenced comparatively late. It seemed, therefore, as if the preliminary treatment had a certain influence on the infection with tuberculosis in guinea-pigs, but the result was not great, and further investigations should be made. How this effect, although only slight, was produced, the speaker claimed that it was not due to any weakening of virulence, but by the action of typical antibodies, that acted on the body cells, the action possibly being only explainable from the standpoint of cellular pathology.

Hr. Friedmann believed that with a greater number of animals undergoing the preliminary treatment the results would have been better.

Hr. Wassermann doubted whether immunity could here be spoken of; it seemed more like a super-infection rendered difficult. We knew that if a body had tubercle about it, it was difficult to infect it afresh.

AUSTRIA.

Vienna, Sept. 22nd, 1907.

SWIMMERS AND ALBUMINURIA.

KIENBOCK has recently been watching the constituents of the urine in prize swimmers, and finds that, out of eleven cases, seven of them had albuminuria. The appearance of the albumin is in greatest quantity immediately after a great effort, when an abnormal quantity of waste product is found in the muscles, which produces temporary toxic albuminuria. He attributes this morbid appearance to the exhaustive loss of oxygen in the muscular system that subsequently deprives the kidneys of finally performing the function of normal elimination. In two of these cases there were quantities of sugar. In twelve cases examined for cardiac trouble, seven of them were found with enormously dilated hearts, having arhythmia and murmurs. From these he argues that swimming is an exercise that should be practised with caution, as considerable damage may be done in a subject predisposed to cardiac affection.

TUBAL PREGNANCY WITH MELENA.

Karczewski exhibited to his clinic the left adnexa uteri, right tube with peripheral ends obliterated, and hydatis Morgagni. The middle portion of the tube was dilated, but had normal lumen at the uterine end. The section of the dilated portion revealed a blood clot with a shaggy chorion.

The left adnexa of the left side were dwarfed and deformed. A section of the lumen exhibited ovules in different stages of degeneration.

This was a tubal pregnancy with rupture forming a secondary hæmatocele, which opened into the large intestine. He considered this hæmatocele was the cause of the withering of the right adnexa, the affection of the left being secondary.

The clinical history showed how different the diagnosis becomes with these complications. The woman was only 24 years of age; commenced to menstruate when 14 years old; married at 20; bore one child, everything ending normally, as she had always been healthy and strong. The second pregnancy aborted about the sixth month, after which she lay in bed six weeks. In July, 1905, she was quite well, and had been since her recovery.

On August 8th she complained of headache, pain in right inguinal region, and went to bed. A week after hæmorrhage from the vagina commenced, followed by fibrous masses on the 18th. After this the hæmorrhage continued three weeks, more profuse than ever, but no pain was present.

On September 3rd colic pains suddenly appeared with fainting. A day after she recovered, and was able to move about till the end of September, when she was again attacked with severe pains in the lumbar region, followed by tenesmus alvi, fever, and a discharge of fæces mixed with pus. This continued till she was removed to hospital on October 14th in a critical condition, pulse 100, evening temperature 37.8 Cent., morning 37.2 Cent., abdomen not enlarged but greatly emaciated. Just over the pubis a hard resistance lost in the pelvis could be detected, and with by-manual movement could be detected above and behind the vagina on the left side, while a small round swelling, about the size of an egg, was found on the right in close contact with that on the left. The pus was still present in the fæces, but the rectal speculum gave negative results. The diagnosis was speculative, having something to do with the abortion and presence of pus in fæces. Stupes over abdomen with rectal douches were continued, the temperature standing 38.0 Cent. in the evening and 37.2 Cent. in the morning. On October 20th temperature was normal and patient much better, while the swelling or infiltration seemed less.

On the night of October 27th she took suddenly ill with pain in the bowel followed by a great rush of blood. By the following morning she was white, feeble, and pulseless. In one of the stools there was a litre and a half of coagula.

It was resolved on the 28th to operate, and, making an incision in the linea alba the small tumour in the pelvis with serous contents was found firmly attached to the peritoneum, the latter protruding into the bowel. After enucleation the cyst was removed, and the second hard tumour on the right side, about the size of a goose's egg, was discovered and removed also. The dilated portion of the tube had next to be removed. A clamp centrally admitted of the external portion of the tube being removed from the posterior attachment, when an opening into a clot revealed a large hæmatocele in communication with the bowel.

After securing the internal organs with catgut, a counter opening was made in the pouch of Douglas, the cavity filled with medicated gauze, after washing with a salt solution the whole abdomen was closed. The temperature immediately fell, but rose on the fourth day to 38. Cent., which continued five days. On the ninth day the gauze was removed, and the temperature fell to normal, where it has continued ever since. She was dismissed on the 17th of December perfectly cured.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

PUBLIC HEALTH POSTERS.—The Public Health Committee of the Corporation has ornamented the city with large posters, headed "Diarrhœa" in type almost offensively observable. There follows a quantity of good advice as regards the feeding of children, and the special precautions needed in hot weather. The advice is excellent, but it is to be feared that the last persons to hang about the streets reading the literature provided on advertisement hoardings will be the mothers of the poorer classes. The same advice has been given by the Ulster Hospital for Children and Women for some years past in a much more effective form, as it is printed on a small fly-leaf, and given to mothers in the extern department of the hospital, and distributed through the maternity nurses. It can then be read at home, and referred to in future.

THE WORKHOUSE SANATORIUM FOR CONSUMPTION.—The Abbey Sanatorium, situated about five miles from Belfast, on a fine site overlooking the Lough from its northern shore, was formally opened last week. The house, once the residence of the late Sir Charles Lanyon, F.R.I.B.A., and the beautiful grounds surrounding it, were purchased by the Guardians for the moderate sum of £5,000, and with the house used as an administration block, and new wards built round it, accommodation has been provided for about 250 patients at a cost of £32,000. Additional accommodation can easily be provided in huts in the grounds, which extend to 33 acres. There are at present 120 patients in the sanatorium, and it is hoped eventually to have all the consumptive cases from the Belfast Workhouse removed there.

QUEEN'S COLLEGE: OPENING OF NEW LABORATORIES.—The work of nearly seven years at the Better Equipment Fund saw its full fruition on Friday, September 20th, when no fewer than seven new laboratories were opened at once, an event, according to Lord Kelvin, without precedent in the annals of science.

LETTERS TO THE EDITOR.

THE INEBRIATES' ACT AND THE PREVENTION OF ALCOHOLISM.

To the Editor of The Medical Press and Circular.

Sir,—In the present state of our Parliamentary machinery it seems evident that attempts at paternal legislation are doomed to failure. The House of Commons occupied fully with high politics has not the time or strength to master the minute details upon the understanding of which the construction of effective laws depends. We shall have to wait a long time for the protection of simple people before the fraudulent drink-cure quacks, about whom a correspondent writes in your issue of September 11th, are made amenable to the law; and we shall have to wait perhaps as long before the vendor of fraudulent "nerve tonics" containing alcohol, as well as the whole tribe of bogus cure-mongers of every class, are brought within the reach of the law. Meanwhile the drink traffic under the cloak of medicinal remedies is assuming enormous proportions. The proprietors of one of these baneful drinks are spending at least £10,000 a year in newspaper advertisements alone; and this affords a measure of the vast consumption of these pernicious disguised intoxicants which is going on. The basis of most so-called wine tonics is simply crude alcohol. It would require a clever palate to distinguish the quality of the liquor contained in a mixture of the character of these potions, and there can be no doubt it is spirit of the cheapest kind their vendors can procure. Vast numbers of innocent people who would shrink from over-indulgence in wine are thus led unknowingly to poison themselves with raw spirit; and at least one death from this cause was recently authenticated. Perhaps the greatest evil arising out of this traffic lies in the facilities it affords for secret drinking among women. Of this I could relate many instances. It is very easy for a woman, who would be unable or afraid to send for drink from the usual sources, to order from her chemist a supply of "tonic," and without shame to indulge her craving to the top of her bent.

I am, Sir, yours truly,
Medical Temperance Reformer.
September 20th, 1907.

SPINAL ANALGESIA.

To the Editor of The Medical Press and Circular.

Sir,—I am much interested in Mr. Edred Corner's remarks on the subject of spinal analgesia. There are several points which to my mind require comment and criticism.

1. With regard to the drug used I would point out that novocain is now recognised throughout Germany, and by all those who have had experience of the two drugs (stovain and novocain) as infinitely the better of the two.

Mr. Canny Ryall has pointed out that with novocain there are none of the complications mentioned by Mr. Corner, except headache. After all, what is headache compared to the usual after-effects of any general anæsthetic when given for a period exceeding half an hour?

2. The immense value of spinal analgesia lies in the marvellous freedom from shock even after the severest operations. Mr. Corner does not emphasize this, which is the greatest advantage of this method of obtaining analgesia.

The pulse remains quiet and full throughout the longest operation, and *does not rise afterwards to any extent.*

3. The duration of the analgesia reported by Mr. Corner is very small. It is quite possible, using the proper method, to obtain an analgesia of two hours duration or more.

Mr. Ryall, who is the pioneer of novocain in this country and has used it extensively during the past year, has had uniformly good results.

Dr. P. H. Parsons recently anæsthetised a patient for me with 10 c.c. of a 1 per cent. solution of novocain to which had been added four drops of 1 in 1,000 synthetical supra-renin. This a very small and perfectly safe dose. The patient was suffering from intestinal obstruction, and on opening the abdomen I found a condition of volvulus of the cæcum with a growth involving the posterior wall. I excised the whole of the cæcum and performed anastomosis. The patient did perfectly well; the pulse during and after the operation remained below 100, in fact during the operation did not rise above 70. There was entire absence of shock. Within two days the patient was reading when I went in to see her.

I assisted recently in a Kraske's operation of a severe nature. Here again there was an entire absence of shock. Recently a patient with a fractured olecranon, and also a fractured patella was given chloroform and also ether. By the time the olecranon was wired the anæsthetist decided it would be unwise to prolong the anæsthesia as the patient proved a bad subject for both anæsthetics. The patient was very sick for two days, and was in a more or less delirious state for an equal period. Later he was given an injection of novocain for the patella operation, and this proved most successful. The after effects were practically nil.

In any operation where shock is a factor to be considered this method should be adopted. Its drawback is obviously that the patient knows what is going on, which may be disconcerting to both patient and surgeon, especially if the former is a nervous subject. I maintain that this is the only real drawback; but since it can be prevented by preliminary injections of scopolamine and morphine there can be no question as to the course to pursue in all operations where shock is to be feared or a general anæsthetic is contra-indicated.

I am, Sir, yours truly,
H. Beckett-Overy.

Harley Street, W.,
September 21st, 1907.

OBITUARY.

JOSIAH ROBERT JENKINS, M.D.Aber., J.P.

We regret to announce the death at Ruthin, on September 16th, of Dr. Josiah Robert Jenkins, one of the best-known medical practitioners in North Wales. Dr. Jenkins, who had been ailing for some time, was eighty years of age. Until recently he had been the surgeon of Ruthin Prison, and was a justice of the peace for Denbighshire. He also held several other public appointments, and was an ex-Mayor of the town. He leaves a widow, two sons and two daughters to mourn his loss.

JOHN ST. SWITHIN WILDERS, J.P., M.R.C.S., L.S.A.

We regret to record the death of Dr. John St. Swithin Wilders, at his residence, in Birmingham, on September 20th. At one time he took a prominent part in the public life of the city, but for the past 14 years he had been in indifferent health. He was for many years a member of the City Council, a Justice of the Peace, an ardent Conservative, and a pioneer of the Volunteer movement in Birmingham. He studied at Queen's College, Birmingham, and at Paris, and took his diploma as far back as 1858. At the time of his death he was Emeritus Professor of Forensic Medicine at the University of Birmingham, Consulting Surgeon to the Queen's Hospital, the Birmingham Dental Hospital, and the Birmingham and Midland Counties Ear and Throat Hospital.

ARNOLD F. BRADBURY, M.D.Durh., M.R.C.S.

We regret to record that Dr. Arnold Francis Bradbury, of Halifax, died on September 19th from heart disease, at the age of 45 years. As a boy the deceased gentleman became seized with a strong desire to enter the medical profession, and in spite of great obstacles he ultimately succeeded in achieving the object of his ambition. He was educated at Durham University, where he eventually took his M.D. For about fifteen years he practised at Halifax, retiring only a short time since on account of health. He was an ardent Nonconformist, and possessing a kindly nature he was highly esteemed by a large number of friends and acquaintances.

REVIEWS OF BOOKS.

DICTIONARY OF MEDICAL DIAGNOSIS. (*a*)

In these days of bacteriological theories and pathological eccentricities, it is a comfort to turn to a book of good, helpful, healthful clinical observation, well arranged and well written by an experienced physician. Such a book is " A Dictionary of Medical Diagnosis " by Dr. H. L. McKisack, and we commend it without reserve to those who wish either to attain bedside skill or to strengthen their grasp on medicine. It is remarkable for its lucidity of description and its attention to essential detail, no less than for its insistence on guiding principles and its comprehensiveness. Arranged in alphabetical order and supplied with a good index, the work is possessed of such facility of reference as to make the task of handling it a pleasure in itself. Any point can be looked up in a few seconds, and all the needed information found in a reasonable compass. The descriptions are, on the whole, well managed and show the author to be possessed of literary as well as medical skill, and if some are rather bald and unsatisfying, the fact must be attributed to the copiousness of our knowledge of clinical medicine and clinical methods. The article in the examination of the blood is by Dr. Thomas Houston, hæmatologist to the Royal Victoria Hospital, and within the limits to which he is confined he has performed his task well. Similarly a short section on " X-rays in Diagnosis " is from the pen of Dr. J. C. Rankin, physician in charge of the electrical department, and one on " Examination of the Sputum," from that of Dr. J. E. MacIlwaine, medical registrar to the Royal Victoria Hospital. Both give a definite indication of the principles of their subjects, which is as much as could be expected in the number of pages allotted. The illustrations are well-chosen and fairly numerous, the diagrams being especially clear and useful. In every way, indeed, the book may be regarded as one of the best of its kind, and its readers will be amply rewarded by imbibing the enthusiastic and painstaking spirit of the author if by nothing else. Rather more than the proverbial " word of praise " is due to the publishers, Messrs. Baillière, Tindall and Cox, for the get-up and printing of the book are uncommonly good.

ON TREATMENT. (*b*)

DR. HARRY CAMPBELL in his book " On Treatment " has construed the title in such a generous way that everything from medical education to excessive eating, from an account of Dr. Campbell's day to his antics in scaling a 'bus in the rain, are treated of, and a great many other interesting things besides. There was a very popular form of physical competition a few years ago known as the " Go-as-you-please " race, and we are of opinion that some such adjective would aptly denote the nature of this treatise. Not that we complain ; on the contrary, we find it unusually interesting and stimulating, but the title might lead people to expect descriptions of new methods of passing the stomach-tube or the most recent exploits of Teutonic synthetic products. The medical use of the word "treatment" it must be confessed is a specialised and limited one, and the employment of the term in the sense of " discourse " is quite legitimate. The most important point is to discover whether the work is intended for the practitioner, the student, or the public, and here again we were for a time in something of a fix. We thought at first it was for the student, as in the chapter on " Education of the Physician " we seemed to recognise our old friend, the introductory lecture ; but on reaching Chapters VII. and VIII., " On Consultation " and " Quackery," we seemed to have struck a popular harangue ; this supposition was supportable for some time, but Chapter XV., "The Blood-Plasma Therapeutically Considered," finally shattered it, and we were finally reconciled to the " go-as-you-please " theory. Emphasis should be laid on the word " *please*," for the general effect of the perusal of the book is certainly pleasant. Dr. Campbell's ideas and opinions are in the main sensible, orthodox, and reasonable, and if he falls at times into the literary trick of trying to " make a platitude plausible by making it pompous," it is because he is no more than human, and many of the remarks that he makes on well-known subjects are those which he has no choice but to make. Here and there some real " tips " are to be found, and there is a great deal of suggestive value throughout. We must protest, however, in the name of the profession against the doctrine, enunciated under the head of " Humbug," that a physician is ever justified in truckling to falsehood. The truth may be at times suppressed, that is, the physician may say as little as possible on a subject, in the interest of the patient, but the false should never be suggested. Even at the risk of not becoming a " great physician," the medical attendant should establish a character for trustworthiness which nothing can shake. There is a great deal of false sentiment about " breaking " bad news to patients, but apart from any principle, we have never known any real harm accrue from the truth being tactfully put when necessary. Medical men doubtless should always dwell on the bright and hopeful features of a case, and give a patient what heart they can ; but they should remember that the distinction between them and the quack is one of kind and not of degree. Save for this blemish we can heartily commend Dr. Harry Campbell's book to the practitioner in his lighter moments ; it will form a pleasant substitute for a siesta on a Sunday afternoon.

THE DRINK PROBLEM. (*a*)

"THE Drink Problem " belongs to Messrs. Methuen's New Library of Medicine, a series of books on medico-sociological subjects by various authors. Dr. Kelynack, who edits the volume before us, has secured no fewer than fourteen collaborators, and it may be said at once that the value of their contributions is markedly unequal. Some of the sections are exceedingly good, notably, perhaps, those by Dr. William C. Sullivan on the "Criminology of Alcoholism," by Dr. Harry Campbell on the " Evolution of the Alcoholic," and by Dr. Arthur Newsholme on " Alcohol and Public Health " ; some are of average interest and merit, and some—to put it mercifully—appear to have been written in a hurry. On the whole, however, it may be safely asserted that the standard is high ; quite a respectable number of facts are given, theories and remedies are presented very fairly, and the better chapters are free from rant and special pleading. We have to remember, however, that the book is one for the intelligent public, and it is certain that it may have an excellent influence with those who are prepared scientifically to study the subject for themselves, as the dangers and allurements of alcohol are set forth in such a way that a decided opinion may be formed on the facts given. The scientific temperance reformer, unfortunately, generally finds himself in a difficulty when he comes to suggest a remedy—at any rate, any remedy short of prohibition, which is, of course, the logical cure for the evils of drink, and which he recognises to be impossible as the world is constituted at present. The fact is that he does not like to admit the real state of affairs, namely, that under modern conditions of industrial und urban life alcoholic drink is the practical soporific for man's inhumanity to man, and that prohibition would (if carried) create riots to which the agitations of the Corn Laws period would be

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(*a*) " A Dictionary of Medical Diagnosis." By Harry Lawrence McKisack, M.D., M.R.C.P., Physician to the Royal Victoria Hospital, Belfast. London: Bailliere, Tindall and Cox, 8 Henrietta Street, Covent Garden. 1907.

(*b*) " On Treatment." By Harry Campbell, M.D., B.S., F.R.C.P., Physician to the North-West London Hospital and to the Hospital for Diseases of the Nervous System. London: Bailliere, Tindall and Cox, 8 Henrietta Street, Covent Garden. 1907.

(*a*) " The Drink Problem by Fourteen Medical Authorities." Edited by T. N. Kelynack, M.D., M.R.C.P., Honorary Secretary to the Society for the Study of Inebriety. Two diagrams. London: Methuen and Co. 7s. 6d. net.

as nothing. It may be taken as axiomatic by all temperance workers that alcohol will be the last evil factor in social life to be removed by reform, and that, hard as it may seem, all legislation and regulations and high licensing are mere momentary symptomatic expedients. Give every man his plot of land, his decent house, his regular work, his games and exercises, and perhaps he will be prepared to renounce his drink; but till then alcohol is the only compensation he has for a life of semi-bondage, often of semi-bestiality, and he will barricade the streets the moment any Government tries to cut his beer off. To pass to another subject, may we implore the editor and his contributor, Mrs. Scharlieb, to abjure that inexpressible vulgarism, the verb "to overlay"? The word, as well as the act it denotes, has come to us from a class which habitually confounds "to lie" with "to lay," in fact, supersedes the use of the former by that of the latter. But that is no reason why we should "paint our mother's cheek," as Professor Clifford Allbutt has it. Still, as has been said, "The Drink Problem," on the whole, is a wise and temperate exposition of a great and many-sided evil; it may safely be placed in the layman's hands as having both good sense, good feeling, and authority.

ALCOHOL AND MANKIND (*a*).

Around the study of man's relation and reaction to alcohol cluster many problems of peculiar intricacy. Many attempts have been made to determine the precise etiology of the human craving for alcohol and the exact action of this chemical agent on animal tissues. The scientific study of alcohol and alcoholism has too often been warped by prejudice or rendered imperfect by the intrusion of moral and emotional or economic and political influences. Since medical writers and investigators have taken up this question as a part of the great medico-sociological study of mankind, order has been brought into a subject where confusion of thought and expression were conspicuous, and rational suggestions for prophylaxis and treatment of alcoholism in its varied forms are now being presented with a scientific precision and calmness which augurs well for the future. Among recent works dealing with the so-called drink problem the monograph prepared by Sir Victor Horsley in collaboration with Dr. Mary Sturge, merits a foremost place. The authors claim to have "put forward the present state of knowledge of alcohol solely on the basis of experimental, anatomical, and statisical evidence," and although they write as convinced abstainers from alcohol their presentation is comprehensive, judicious, and eminently scientific. While no new facts or records of original investigations are noticeable in these pages, the most reliable results of numerous trustworthy observers are conveniently summarised, and the logical and practical conclusions of recent researches clearly enunciated. Medical practitioners will be particularly interested in the opening chapters, which deal with the evolution of medical opinion regarding the value of alcohol as a drug. In a striking diagram it is shown that since 1852 "alcohol and milk have practically changed places as regards the extensiveness of their use." After a brief reference to the chemistry of alcohol and alcoholic beverages and an all too short description of the properties of cell life and the structure of the nervous system, the authors pass to the most serious and valuable sections of their work, a study of the effects of alcohol on intellectual processes and on the various parts of the nervous system. Here will be found reference to the work of such investigators as Kraepelin, Aschaffenburg, Fürer, Kürz, and others. Even when dealing with the terrible effects of alcohol-produced disease and degeneration of the nervous structures, the authors still maintain a strictly temperate and scientific presentation of the case, and in evidence we may quote their concluding remarks in regard to this matter—"alcohol tends to shorten life both by causing widespread degeneration and also by bringing on prematurely the special changes of old age. These changes in the case of the nervous system are, of course, especially to be dreaded because of the accompanying mental deterioration—a deterioration which frequently makes life a misery, and which, at the very least, renders it useless and ineffective."

The physiological and pathological action of alcohol on the other systems of the body also receive attention.

The work is excellently illustrated, and for the coloured lithographs especially much praise is due. In a measure rarely attained in so-called temperance works, pictorial exaggeration has been excluded, and accuracy in details obtained. In the minds of old-fashioned practitioners trained in the ancient days of what may be termed the alcoholic dispensation, and amongst the prejudiced and ignorant in all classes of society, many of the statements and some of the conclusions found in this volume will doubtless be irritably denied or clamorously contended, but at least in the main we have no hesitation in recommending this book as a most reliable and valuable contribution to the scientific study of a subject our attitude to which must in the end be guided and governed by the verdict of science.

The work throughout is written with a simple directness and avoidance of obscurity and redundance which will make it welcome to every intelligent layman. A glossary of technical terms is provided for the non-medical reader.

We trust a copy of this admirable manual may find its way to every medical practitioner and school teacher throughout the land.

ST. THOMAS'S HOSPITAL REPORTS.

The present volume of St. Thomas's Hospital Reports (*a*) is a more bulky volume than any of its recent predecessors, and the increase of size is chiefly due to fuller details being given of the cases which have been treated during the year. The tabulation of cases in the various departments is excellent, and a reader interested in any particular subject has no difficulty in finding his way to the information he desires. The use of the authorised nomenclature for diseases and injuries is to be praised, and we hope to see other hospitals follow in this particular the example of St. Thomas's.

All cases of special interest are detailed with fairly full notes, quite adequately full as regards clinical details. The pathological information is, however, insufficient. This is most noticeable in that part of the surgical report dealing with tumours, and in the *post mortem* records in the medical report. The details given are so few as to be valueless, and one is left in doubt as to the real nature of many of the cases. *Obiter dicta*, such as "carcinoma in some portions distinctly squamous, in others spheroidal" (p. 208), do not elucidate a clinical history. Again, the discovery of "a malignant growth" (nature unstated) in the liver ten years after the removal of the patient's eye for sarcoma, is not sufficient evidence of "recurrence" (p. 91). We would have liked also a little more information on the working of the clinical laboratory. St. Thomas's greatly prides itself on having inaugurated one of the earliest clinical laboratories, and those in charge of clinical laboratories elsewhere are eager to learn from the experience there acquired; the present report devotes exactly one page to the work of the laboratory. On the other hand, the descriptions of the specimens added to the museum are admirably full, and should serve as an example to curators generally. Individual papers on various subjects are contributed by Messrs. Nitch and Corner, and Drs. Dudgeon and Cassidy, while Mr. Robinson writes a graceful memoir of the late Mr. John Croft, who had been on the staff of the hospital for over thirty-five years.

(*a*) "Alcohol and the Human Body: An Introduction to the Study of the Subject." By Sir Victor Horsley, F.R.S., F.R.C.S., M.B., B.S. Lond., Hon. M.D., Halle, &c.; and Mary D. Sturge, M.D.Lond. With a Chapter by Arthur Newsholme, M.D., F.R.C.P., D.P.H. Pp. xxv. 370. London: Macmillan and Co., Limited. 1907. Price 5s. net.

(*a*) "St. Thomas's Hospital Reports." New Series. Edited by Dr H. G. Turney and Mr. W. H. Battle. Vol. XXXIV. Pp. xiv. 637 London: J. and A. Churchill, 1906. Price 8s. 6d. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT OBSTETRICAL LITERATURE.

Pyelo-nephritis in Pregnancy.—Fournier (*Zentralbl. für Gynäk.*, Nr. 38, 1907) in a paper on this subject says there are two principal factors to be considered in the causation of this complication of pregnancy. Firstly, compression of the ureters; secondly, descending infection, *e.g.*, bacterium coli and ascending infection, *e.g.*, gonococci, former renal disturbances, and finally congenital malformations of the ureter and pelvis of the kidney. The disease can be divided into two groups:—(1) That produced by the bacterium coli, in which one frequently finds the bacterium in the urine; (2) that produced by the gonococcus, in which the micro-organism is rarely found in the urine. The former is much graver than the latter. The presence of stone in the kidney makes the prognosis more serious. As a rule the prognosis is seldom bad for the mother, but always momentous for the child. Under the influence of proper treatment from the first the disease can improve. Disinfection of the intestinal and urinary systems is the most satisfactory treatment. G.

Premature Detachment of the Normally Situated Placenta.—The most important causes of this according to Gaston (*Zentralbl. für Gynäk.* Nr. 38, 1907) are albumenuria, injury, and endometritis. The most characteristic symptoms are the sudden onset, intense abdominal pain, great hardness of the uterus from tetany, and the abnormal appearance of the uterus which resembles a more advanced period of pregnancy. The prognosis is very bad, both for mother and child. The histological changes to be noted are: In the uterus atrophy of the mucous membrane and degeneration, in the placenta hypertrophy of the decidua, blood clots, alveolar endometritis, which extends over the whole decidual tissue and atelectasis of a great number of villi. When the symptoms are not severe the patient should be kept at rest in bed, labour then usually comes on spontaneously. If the cervix is dilated the membranes must be ruptured and the uterus emptied as soon as possible. If the cervix is not dilated the Champetier bag or Bossi must be employed, or the vaginal cæsarean section if tetany of the cervix be present. G.

Version for Placenta Praevia.—Jolly (*Münchener med. Wochensch.*, 1906, Nr. 25) says in opposition to the more surgical methods of treatment that this remains always the most important means of treating the placenta prævia. The high fœtal mortality is not so much due to the version as to the frequency of debility of the infants since the labour is very often premature. Version may be performed when it is possible to introduce one or two fingers through the cervix. As much liquor amnii as possible should be allowed to escape. The diminution in the uterine contents excites labour, and thus a rapid delivery of the child. G.

The Complications of Septic Abortions, their Ætiology, Treatment, and Prognosis.—Seegert (*Med. Klinik*, 1906, Nr. 31) divides the causes into internal and external. The internal causes being those which by producing intoxication terminate the pregnancy. The external causes are regarded by the author especially as the manifold injuries to which women of the working class are liable during the early months of pregnancy. In cases of feverish abortion, when the cause of the fever is only a decomposition of the uterine contents, the proper treatment is to remove the source of the sapræmia as soon and as carefully as possible, that is, the uterus must be emptied without a sharp spoon or a sharp curette or an ovum forceps. If the internal os is not dilated, laminaria tents or an iodoform gauze tampon in the cervix act quickly and well without producing much injury. If the digital removal of the uterine contents does not produce a cure, and if the bacteria have already extended into the blood or the lymphatic system of the mother, the treatment and prognosis depend on the nature and the virulence of the bacteria, on the action of their products of metabolism, and on the resisting power of the mother. When there is a lymphatic infection a parametritic exudate may arise, or it may result in a phlegmasia alba dolens. With such treatment as opium, heart tonics, cold packing, etc., the prognosis is favourable unless the rare "erysipelas malignum internum" (Virchow) should arise, in which the cellulitis extends into the connective tissue of the trunk. If in cases of infection by the blood stream there should be a rapid invasion of the entire body by pathogenic micro-organisms, this "foudroyant" sepsis has a fatal result in a few days or even hours after the abortion with the symptoms of cardiac paralysis. In cases of septic endocarditis, in which an injury of any sort is not to be discovered in the genital tract, the prognosis remains very doubtful even after complete emptying of the uterus. If the hæmatogenic infection in septic abortion produces a localisation of the bacteria in the ovarian and pelvic veins, the thrombophlebitic form of sepsis or "pyæmia" is the result. Pulmonary embolisms, joint abscesses, infarctions or abscess formation in the kidney (recognised by the bloody urine) show how serious the prognosis is. If the abscesses should be subcutaneous, intramuscular, or periarticular the prognosis is relatively favourable. G.

Cystic Enlargement of the Ovaries in Cases of Hydatidiform Mole.—Goullioud (*Rev. de gyn. et de chir. abdom.*, 1907, No. 1) records the case of a patient, æt. 25, IIpara, who began to bleed about the fifth month of her third pregnancy. On examination two cystic tumours as large as a child's head could be felt, one on either side of the uterus, and both quite mobile. Soon afterwards a hydatidiform mole was born. The convalescence was complicated by phlebitis. Except for some uterine douching and treatment of the phlebitis nothing was done. During this time the tumours began to diminish in size till they gradually returned to the size of normal ovaries. Two years later the woman again became pregnant. The pregnancy advanced normally till the fourth month when abortion occurred. There were no ovarian tumours to be felt. Six months after this she again became pregnant, and went normally to full term without any sign of an ovarian tumour. There was, therefore, in this case a cystic degeneration of the ovaries complicating hydatidiform mole, which would be better called a cystic tumefaction, since the process disappeared and the ovaries returned to their normal size, and were capable of exercising their functions in regard to menstruation and ovulation. Removal of the ovaries therefore in those cases is quite false. G.

Carcinoma of the Ovaries in Cases of Carcinoma of the Stomach, of the Intestine, and of the Bile Ducts.—Goullioud (*Rev. de gyn. et de chir. abdom.*, 1907, No. 2) in a paper on this subject says that malignant tumours of the ovaries frequently complicate cancer of the stomach, intestine, and bile ducts, and are generally bilateral. On the other hand, epithelioma of the ovary may cause metastases in the intestine which resemble primary tumours of the intestine. One must, as a rule, consider malignant tumours of the ovaries as metastases. Therefore in cases of cancer of the pylorus, one must always look for metastases in the ovaries before one decides on operation, and during the operation itself one must never forget to examine the ovaries. In the same manner, when malignant tumours of the ovaries are present the intestines and stomach must be very carefully examined, especially when vomiting and ascites are present. When ovarian tumours are complicated with metastases in the intestines and stomach, although operation should never be shirked, the prognosis must always be regarded as being very doubtful. G.

Fatty Degeneration of the Uterus in Pregnancy.—Ciulla (*Zentralbl. für Gynäk.*, 1907, Nr. 37) in a paper on this subject comes to the following conclusions. From the beginning of the second last month of pregnancy a true fatty degeneration of the uterus exists. This degenerative process falls upon the hyperplastic muscle fibres only. It destroys them, and then produces a fatty infiltration process in the hypertrophic fibres, which in this manner are reduced in bulk so that they may return to their normal shape and size. This fatty degeneration at the end of pregnancy has a moderating effect on the extraordinary irritability of the uterine muscle during pregnancy and also during labour, and we can thus explain in cases of exaggerated degeneration the uterine inertia, and in cases of incompleteness or absence of degeneration the excessive and cramplike contractions which occur during labour. In the same manner we can explain subinvolution and hyperinvolution during the puerperium. We may consider excessive and premature fatty degeneration to be the principal cause of prolonged pregnancy, just as in premature labour there may be an absolute failure of this degenerative process. The fat which is thus derived from the uterine muscle fibres can help to nourish the fœtus during the last two months, and passing into the maternal blood prepares the way for lactation. The fat obtained during active involution is made use of for the milk secretion. G.

RECENT SURGICAL LITERATURE.

The Separation of the Urine of the Two Kidneys.—Luys (*Med. Record*, August 3rd, 1907), the inventor of the Luys' separator, points out the frequent necessity in renal surgery for obtaining the urine of the two kidneys separate. This may be done by ureteral compression, ureteral catheterization or intravesical separation of the urine. Ureteral catheterization has many objections. There is considerable risk of infecting a healthy kidney. It is often untrustworthy as the ureteral sound may not be of proper size, and may slip out; or the ureter may be injured, causing a mistaken diagnosis of hæmaturia, and the kidney may secrete abnormally, due to abnormal excitation. Also the difficulties in ureteral catheterization require considerable experience to overcome them. Endovesical separation of the urine has the following advantages over ureteral catheterization: (1) It is more simple; (2) it may be applied in more cases than ureteral catheterization; it is devoid of danger; the information given by the separator, when properly applied, if possibly not better is at least as exact as that furnished by ureteral catheterization. S.

Perforation of the Gall-Bladder in Typhoid Fever.—Brandon (*Canadian Practitioner and Review*, August, 1907) reports the following case. The patient, female, æt. 18, was being treated for enteric fever which ran a typical course for over three weeks, when one night she was seized with severe pain in the right hypochondiac region. There was considerable tenderness and slight rigidity of the abdominal muscles. Temperature 102°, pulse 120. Perforation was suspected. Fluids were stopped by the mouth, and a hypodermic of morphia relieved the pain. Next morning the abdomen was slightly tympanitic. The pain had descended, and was directly over McBurney's point, and was associated with considerable dulness on percussion, simulating appendical trouble. There were no signs of collapse save the gradual dropping of the temperature and a slight change in the character of the pulse. A diagnosis of perforation in some form was made, either of the cæcum colon or appendix. Operation was decided on, but the patient suddenly collapsed, became pulseless, and soon expired. Post-mortem showed the peritoneal cavity filled with greenish yellow bile. The appendix was small and perfectly normal. The gall-bladder showed two perforations, one the size of the tip of the index finger, and the other that of the little finger. There were also two or three ulcerated patches. In all the literature on this subject there are only thirty-five cases of perforation of the gall-bladder due to enteric fever. Five were operated on, and three of these survived. All the cases not operated on proved fatal. S.

The Treatment of Surgical Tuberculosis by Hyperæmia (Bier—Schmieden, of Bonn *Med. Record*, August 17th, 1907,) points out that Bier's treatment of inflammatory processes increases the normal reaction of the parts, artificially increasing redness, swelling, and heat. It is difficult to arrive at the proper degree of hyperæmia, and it is absolutely wrong to think that if little is good, more is better. A broad (6 c.m.) soft rubber bandage is applied slowly and evenly round the extremity, proximally to, but not too close to the tuberculous joint. Tuberculosis of the wrist joint, for instance, is treated regularly with a bandage above the elbow. Each turn of the bandage overlaps the preceding one. These bandages must not cause pain either at the place of application or in the diseased joint. The extremity below the bandage soon begins to swell in a moderate degree and assumes a bluish red colour. It remains warm, and the pulse remains entirely unchanged. The hyperæmia bandage in tuberculosis is applied only for a few hours per day, and during this time all other bandages are removed, sterilized gauze being placed over discharging fistulæ. The joint is not kept in fixation. The tuberculous joint must be movable after the disease has healed to fulfil the purpose of this treatment. The first result of this treatment is abeyance of pain. Inflammatory contractures also soon disappear, and active as well as passive movements are again possible. Every excessive use of the joint should be avoided. In the further course of the treatment the swelling subsides, large fungous masses are converted into hard connective tissue, which latter, by further treatment, is also absorbed. The contour of the bones becomes visible, tuberculous fistulæ even extending to the joints or bones close. Sometimes with less perfect technique cold abscesses develop. These are never injected with antiseptics, but opened and treated with cupping glasses. Treatment by hyperæmia requires much time, nine months or more in bad joint affections. The treatment is very simple and can soon be applied by the patient himself or by any one who is in the house with him. Almost all cases of joint tuberculosis in Bier's clinic are treated by hyperæmia. It is to be regretted that tuberculosis of the hip joint cannot be treated in the same way. Hyperæmia of the shoulder-joint, however, is practicable. Especially favourable results occur in the ankle, elbow, and wrist. In severe knee-joint disease, where ankylosis has already occurred, resection is practised to shorten the time of treatment. In less severe cases extension and splints are required when the patient is not in bed. The exutative form (hydrops) is never treated by hyperæmia; aspiration, and injection of iodoform emulsion being used. In combination with the elastic bandage cupping glasses are frequently used. They are employed in all cases of beginning softening and of abscesses, which may or may not have fistulous openings. The rarefaction of air is accomplished in smaller cups by a hollow ball, in larger ones by a pump. They are applied intermittently for three-quarters of an hour, being five minutes *in situ*, and three minutes off. A red not a blue hyperæmia is aimed at. By use of the cupping glasses all detritus is evacuated daily through the fistula and hyperæmia of its walls and of the abscess cavity is induced. Hyperæmia is also applicable in tuberculous diseases of the testes, in tendon sheaths, serous membranes, &c. Bier, in the fifth edition of his book, "Hyperæmie als Hielmittel," says: "Formerly I considered the hyperæmic treatment of tuberculosis as good; now I consider it the best." S.

MEDICAL NEWS IN BRIEF.

Maternity Hospital Case.

ADA CHARLOTTE CHOWNE, who wore a nurse's uniform, was indicted at Newington Sessions on September 20th for neglecting three children, named Lena Rivi Murio, Ena Pratt, and Una Edwards, in a manner likely to cause them unnecessary suffering and injury to health.

Counsel said the accused was the matron of an institution described as the Stockwell Maternity Hospital and School of Midwifery, and she had been in the habit of receiving young children to nurse. With regard to the first child the facts were that a young Italian woman, becoming pregnant, her mistress sent her to this institution. The baby was left there, the mistress undertaking to pay 7s. per week. After a time it was proposed to remove the institution to Brixton, and the prisoner asked the mother to take the child away. When the mother did so she found it in a deplorable condition, and her mistress communicated with the Society for the Prevention of Cruelty to Children. An officer of the Society called at the institution and found six children there, although none had been registered under the Infant Life Protection Act. Defendant declared that some of the children belonged to probationer nurses at the hospital. In the case of Ena Pratt, the mother, who had been addicted to drink, had paid the prisoner 19 guineas to be trained as a midwife, but she left the hospital on June 29. Little Ena Pratt was in a dying condition, and the child Edwards was in a state similar to that of Murio.

For the defence it was said the prisoner was a respectable professional woman, who came in for a fortune of £30,000 to £40,000. She married a man who ran through all her money, but she kept to him for the last years of his life. She then associated herself with this "home," which was not a public institution, but a maternity home—a means of earning a livelihood by helping women.

Mrs. Chowne went into the witness-box and emphatically denied the allegations of cruelty. She said that she was fond of children, or she would not have carried on the institution.

Mr. Campbell: But you carried it on for profit?—There was no profit—I only just got a living. Continuing, she said she did not know that under the circumstances she had to register the children.

Evidence was also given that the condition of the children was not due to carelessness or neglect, but the state of their health.

The jury found the prisoner guilty of neglecting the Italian child and Ena Pratt.

Mr. Loveland postponed sentence.

Death Under Anæsthetic.

AT an inquest on September 18th on the body of Reginald Gregory Lund, 46, late of Belmont Mansions, Chelsea, Dr. Stephen Fenwick gave details of an operation which was performed on the deceased, who was suffering from a growth on his tongue. About six weeks previously, at the Charing Cross Hospital, half of the deceased's tongue was removed, together with some glands in the neck. The operation was quite successful, but on September 15th the deceased had again to be operated upon for lockjaw, and he expired while under an anæsthetic. Dr. Fenwick said the deceased had a weak heart, a complaint which was aggravated perhaps by the distress of the operation. Mr. Waterhouse, who performed the operations, said they were successful. The immediate cause of death was heart failure, and the jury returned a verdict to that effect.

Metropolitan Asylums Board.

AN ordinary meeting was held on the 14th inst. at the office of the board, Mr. J. T. Helby, the chairman, presiding. Letters were read from the Local Government Board stating—(*a*) that they were advised that the estimated cost of the proposed additional storage accommodation for coal at the Eastern Hospital was unnecessarily high, and asking the managers to reconsider their proposals with a view to a reduction in the expenditure; and (*b*) that they were prepared to issue an order authorising the proposed expenditure on the goods reception station and porters' lodge at Joyce Green Hospital, but that they were not prepared to sanction so heavy an expenditure as £3,042 on the erection and drainage on the block of eight cottages, and asking the managers to reconsider the matter with a view to a reduction in the cost of that portion of the scheme. Mr. Lower said he was not surprised that the Local Government Board had objected to the proposed expenditure of nearly £400 on each of the cottages. The largest rooms in most of the cottages were less than 11ft. square, and in his opinion they were not worth anything like the proposed amount. The board had been charged by newspaper writers and others with extravagance, and there seemed to be reason for it, because the Local Government Board had constantly to object to their estimates for proposed works. After further discussion, the letters were referred to the Works Committee. The Local Government Board wrote stating that they were prepared to assent to the provision of a central laboratory for the preparation of anti-toxin serum and for bacteriological work, but they would not be prepared to authorise a total expenditure on the works of more than £6,500; and also that they were advised that a saving of not less than £1,000 might be effected by the erection of the laboratory on the Belmont site instead of at Peckham, and they asked the managers to reconsider their proposals in accordance with these views.

Queen's College. Belfast.

THE new laboratories of the Queen's College were opened on Friday last. Considerable disappointment was felt owing to the fact that Lord Kelvin, who had promised to perform the inaugural ceremony, was unable to be present. The laboratories were therefore opened by Sir Otto Jaffe, the chairman of the Better Equipment Fund, and a munificent benefactor to the College, and the address prepared by Lord Kelvin for the occasion was read by his nephew, Mr. James Thompson, himself the son of a former professor in the College. In this address Lord Kelvin traced the evolution of the College from the old Royal Academical Institution, and pointed out plainly that the natural goal is the establishment of an autonomous University in Belfast. Two of the subsequent speakers were in cordial agreement with this weighty opinion, and pressed it home—Sir Christopher Nixon, Vice-Chancellor of the Royal University of Ireland, and Professor Letts, the senior of the science professors in Queen's College. The new buildings may be briefly described as follows:—A series of buildings in the north wing of the College, called the Harland Laboratories, after the late Sir Edward Harland, whose widow contributed largely to their cost, are devoted to physics and engineering. The chemical or Donald Currie Laboratories complete the chemical department of the College, and give every facility, not only for the ordinary practical classes for medical and other students, but also for research work and advanced technical chemistry. The pathological or Musgrave Laboratories have been enlarged by the addition of several new rooms, including one 43 by 28 feet, which forms the professor's private laboratory. In it Professor Symmers rejoices in what he confidently believes is the largest private laboratory in the world, as far as pathology is concerned. There is also a bacteriology room 27 feet square, and a demonstrator's room 22 by 15 feet. The additions to the physiological or Jaffe Laboratories include a practical classroom, fitted with benches having pulleys, shafting, and Kershaw drums for experimental purposes, a practical experimental room, a histology room, a galvanometer room, and a lecture room. To the old medical rooms have been added a large new surgical lecture theatre, with operating table, lift to the basement, preparation room, and many other conveniences for work. The natural history department has also been provided with large biology laboratory, professor's room, photographic room, and botanical glass-house on the roof.

Women Doctors in Austria.

FEMININE ambition has now achieved in Austria a success which is all the more valuable as it has been the object of their aspiration for several years. The Minister of Public Instruction has declared that henceforward girls and women may enter the universities under precisely the same conditions as men, they can give private lectures in clinical hospitals, and be appointed assistants by the professors. The Minister at once granted the first petition of a lady to act as private lecturer and instructor at Vienna University. This lady, Fräulein Dr. Elise Richter, forty years of age, has for the last four years petitioned the professors of the university for permission to lecture upon Roumanian philology. The professors were willing, but the then Minister refused his ratification. The female medical doctors also demanded to be allowed appointments as assistants, and the Ministry caused an inquiry to be made in all the Austrian universities and clinical hospitals. The result of the investigation was that only a few professors opposed the admission of women as private lecturers and assistants, hence the inquiry culminated in to-day's decree by the Minister.

St. Bartholomew's Hospital and Medical School.

During the past year the following changes have taken place in the teaching staff:—

Dr. Christopher Addison, who was formerly Dean of Charing Cross Medical School, and Professor of Anatomy at the University College, Sheffield, has been appointed Lecturer and Senior Demonstrator of Anatomy.

Mr. W. D. Harmer has resigned the Assistant Surgeoncy, and has been appointed Surgeon in charge of the Department for Diseases of the Throat and Nose. Mr. F. A. Rose has been appointed Assistant Surgeon for Diseases of the Throat and Nose. Mr. G. E. Gask has been appointed Assistant Surgeon and Teacher of Clinical Surgery.

Dr. W. S. A. Griffith has been elected Physician Accoucheur with charge of outpatients, and will give part of the Clinical Lectures on Diseases of Women. D. H. Williamson has been elected Assistant Physician Accoucheur and Clinical Lecturer in Midwifery.

Dr. J. A. Willett has been appointed Demonstrator of Midwifery. Mr. C. E. West has been elected Assistant Aural Surgeon. Mr. C. Gordon Watson has been appointed Surgical Registrar, and has resigned the Demonstratorship of Anatomy.

Mr. L. B. Rawling has been appointed Demonstrator of Operative Surgery. Mr. R. C. Ackland has been appointed Dental Surgeon, and Mr. F. Coleman Assistant Dental Surgeon. Mr. R. C. Elmslie has been appointed Demonstrator of Pathology and Dr. H. Pritchard and Mr. H. G. Ball have been elected Junior Demonstrators of Pathology. Dr. H. G. Adamson has been appointed Chief Assistant in the Department for Diseases of the Skin.

Dr. C. M. H. Howell has been elected Junior Demonstrator of Physiology, and Mr. T. S. Lukis and Mr. C. T. Neve have been appointed Assistant Demonstrators of Biology.

The following awards of scholarships and prizes have been made during the year 1906-7:—

Lawrence Scholarship.—G. T. Burke, J. C. Meade (equal). Brackenbury Medical Scholarship.—E. A. Cockayne. Brackenbury Surgical Scholarship.—P. L. Guiseppi. Matthews Duncan Prize.—R. B. S. Sewell. Kirkes Scholarship and Gold Medal.—G. T. Burke. Walsham Prize.—P. L. Guiseppi. Bentley Prize.—H. J. Cates. Hichens Prize.—S. Dixon. Wix Prize.—A. W. J. Cunningham. Senior Scholarship.—A. P. Fry. Junior Scholarship.—R. G. Hill, C. D. Kerr, J. W. Trevan (equal). Sir George Burrows' Prize.—A. W. G. Woodforde. Skynner Prize.—P. L. Guiseppi. Harvey Prize.—K. Bremer. Treasurer's Prize.—R. G. Hill. Foster Prize.—W. C. Dale. Shuter Scholarship.—R. R. Armstrong.

The Report of the Queen's College, Cork.

The annual report of the president of the Queen's College, Cork, for the past year, which has just been issued, refers at some length to the generous offer which was made by Mr. William O'Brien, M.P., of the whole of his own and his wife's fortune, at their death, for the foundation of a local university or for the support of a truly autonomous college, which offer was accompanied by a further suggestion that on certain conditions a sum of £50,000 might be immediately available.

Dr. Windle goes on to say that this generous offer must have great weight with those whose duty it is to consider the proposals which will be made for the modification and improvement of university education in Ireland. He goes on to point out that the expressions of local opinion which he appends proves conclusively the four points which he enunciated in his previous report, and which he now again emphasises:—

(1) That the relations of the college to the district which it is intended to serve have never been satisfactory, and still remain in an unsatisfactory condition.

(2) That until these relations are placed on a satisfactory footing the college cannot expect to have that number of students which, under normal conditions, it would undoubtedly attract.

(3) That such alterations in the constitution of the college as would place it on a satisfactory footing might be made without any difficulty and without any danger to its academic position by alterations in the charter and without direct legislation should His Majesty issue letters making such alterations in the charter.

(4) That there is a great and general desire throughout the whole of Munster that the college should be made available for the people of the province.

Referring to the work of the College during the past session, Dr. Windle says it is more than twenty years since the College has had so many students in attendance, the number being 261, of whom 77 were new students. He records with satisfaction the establishment of a students' club, the work of which has been an unqualified success. A considerable number of other improvements are also mentioned, notably the erection of an operating surgery theatre which in its design imitates the most modern type of operation theatre in a hospital. Many further improvements are, however, needed, and chief among these Dr. Windle puts forward accommodation for the teaching of chemistry and physics.

Medical Sickness and Accident Society.

The usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society was held at 6, Catherine Street, Strand, London, W.C. There were present: Dr. de Havilland-Hall (in the chair), Dr. F. S. Palmer, Dr. H. A. Sansom, Dr. J. W. Hunt, Dr. M. Greenwood, Dr. W. Knowsley Sibley, Dr. F. J. Allan, Dr. St. Clair B. Shadwell, Mr. H. P. Symonds, Dr. J. Brindley James, and Dr. J. B. Ball. The accounts presented showed that during the first eight months of this year the operations of the Society had been greater than in any similar period of its working. Since January 1st last, nearly nine thousand pounds has been distributed to the members in the shape of weekly sick pay, and good cash bonuses have been given to those who reached the limiting age of 65; yet the funds, which now amount to over £200,000, have received a substantial increase, as the annual income of the Society is considerably larger than its outgo. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

An important concert in the series of twenty Odeon Concerts in aid of the Lord Mayor's Cripples' Fund, and under the Lord Mayor's patronage, was given at Hammersmith Town Hall on Friday, September 20th. Sir John Kirk, the Secretary of the Ragged School Union, again presided, and opened the proceedings with a short speech, pleading very earnestly for the cripples and the cause which the Odeon Company has taken up. The record specially made for these concerts by the Lord Mayor was recited, and could be heard clearly all over the hall.

A scare has been caused at Cleethorpes by a number of people who have eaten potted meat suddenly developing symptoms of irritant poisoning. They are now undergoing treatment. No fatal consequences are anticipated. The whole of one family has been ill, two of the daughters dangerously.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

R. M. P.—The names of the two medical men belonging to the Liverpool School of Tropical Medicine who lost their lives in pursuing scientific work abroad are Dr. Walter Myers and Dr. J. E. Dutton. Dr. Myers died at Para of yellow fever, and Dr. Dutton on the Congo.

Omnibus.—It is not correct to say that the medical officer in question was censured. His abilities were recognised and the smallness of his salary mentioned in such a way that it was clear no extensive duties could have been expected of him. It is unreasonable to suppose that a man, however talented, can do work for which he is not paid, and the more talented men will naturally find freer scope for their abilities in other fields.

Vermin.—There are several preparations of the kind on the market, and we believe they are all of bacteriological origin. They seem all to be harmless, but we are not in a position to say anything positive of our own knowledge; they all have good credentials. You had better write direct to the makers for what they euphemistically term "literature."

Febris.—There is normally a rise in "fever" at this time of year, but the curve for 1907 certainly is higher than for some years past. For the week ending September 7th the number of cases of scarlet fever admitted to hospitals in London rose to 587, as compared with 430, 440, and 557 for the preceding three weeks. Diphtheria and enteric fever showed rather smaller rises.

G. P. I.—The pathology of general paralysis is by no means settled. The theories of Dr. Ford Robertson are by no means accepted by the general body of psychologists. The observations of this gentleman point to there being constantly present certain diphtheroid bacilli in the vessels and affected nervous tissues. He has carried his work to the point of inoculation, and has reported finding like pathological sequelæ in animals.

THE INVENTION OF SPECTACLES.

The invention of spectacles has been attributed to Roger Bacon in the thirteenth century, and also to Alexandro di Spina and Salvino degli Armati, distinguished Italians of the early fourteenth century. These ophthalmic aids, however, are probably of a much older date. Magnifying glasses, at least, must have been in use among the ancients, for it is difficult to believe that the perfection of gem-cutting which they attained could have been acquired without their assistance. The Chinese, too, claim credit for having used them before the Christian era, and the passage in Holy Writ, "Now we see through a glass," is considered by some commentators to be a mis-translation, and should read "through glasses."

W. S. H.—The dates of the various developments are as follows for the infant:—Tears, about the second month; sweat, about the same time; saliva—in any quantity—about the fourth month; appreciation of sights and sounds, about the end of the first week; ability to raise the head, about two months; to sit up, seven months; to stand, twelve months.

R. G. I.—The returns of the Registrar-General for Ireland show a disturbing prevalence of consumption. There were in 1906, 74,427 deaths registered in the country, and of those 11,756—a number equal to 15.8 per cent. of the total—are attributed to tuberculosis. In this respect interest will be found in the comparisons between the death rate from tuberculosis in the three kingdoms between 1864 and 1906. In England and Scotland the returns show decreases from 3.3 to 1.6, and from 3.6 to 2.1 per thousand respectively, but in Ireland there is an increase from 2.4 to 2.7.

Senility.—There are a good many authentic cases of centenarians in this country. Some time ago the case of an old lady who had died in the department of the Haute Garonne, France, at the well-nigh incredible age of 150, who had lived the best part of her life on goat's milk and cheese, was reported. There is also the case of James Grieve, of Ardkinglass, Argyllshire, who is now 107 years of age, and who repudiates what he calls dietetic fads, declaring that he has always been in the habit of eating anything he fancied. At Horncastle, the Rev. Thomas Lord, now in his hundredth year, still occupies the pulpit of his church on Sundays; at Cleeve, Somerset, a well-known resident, Mrs. Honor Coleman, is in her 107th year. Many other instances might be given of centenarians of England, to say nothing of well-known personages like Sir Andrew Lusk and Sir Henry Pitman, whose ages are very little short of five score. Ireland has, in proportion to population, the largest number of aged people. In 1905, the last year for which we have complete returns, seventeen centenarians died in that country in the workhouses alone. The oldest of these, a Limerick man, was no less than 113 years of age.

Anon.—(Imprisonment for Debt.)—Many thanks for the cuttings. We cordially endorse the sentiments.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 2ND.

St. Mary's Hospital Medical School.—3.30 p.m.: Annual Presentation of Prizes and Introductory Address by Professor Osler, M.D., LL.D., F.R.S. 7 p.m.: Annual Dinner of Past and Present Students at the Whitehall Rooms.

WEDNESDAY, SEPTEMBER 25TH.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. L. Mummery: Clinique. (Surgical.)

THURSDAY, SEPTEMBER 26TH.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.)

FRIDAY, SEPTEMBER 27TH.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. S. Stephenson: Clinique. (Eye).

Vacancies.

University of Manchester.—Senior Demonstrator in Physiology. Salary, £150 per annum. Applications to the Registrar.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Physician. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon. Salary, £20, washing allowance £2 10s. with board and residence in the Hospital. Applications to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Assistant Casualty Medical Officer. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications to the Secretary. (See Advt.)

Manchester Royal Infirmary.—Resident Surgical Officer. Salary, £150 per annum, with board and residence. Applications to Walter G. Carnt, General Superintendent and Secretary.

Farringdon General Dispensary, 17 Bartlett's Buildings, Holborn Circus, E.C.—Resident Medical Officer. Salary, £120 per annum, with apartments, coals, gas, and attendance. Applications to the Honorary Secretary.

Kent County Asylum, Maidstone.—Fourth Assistant Medical Officer. Salary, £175 per annum, with furnished quarters, attendance, coals, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

Metropolitan Borough of St. Marylebone.—Medical Officer of Health. Salary, £600 per annum. Applications to James Wilson, Town Clerk, Town Hall, Marylebone Lane, Oxford Street, W.

Durham County Hospital.—House Surgeon. Salary, £120 per annum, with board and lodging. Applications to Wm. R. Wilson, Secretary, 68½, Sadeler Street, Durham.

Jersey Dispensary.—Resident Medical Officer. Salary, £120 per annum, with furnished quarters and attendance. Applications to the Secretary.

City of London Hospital for Diseases of the Chest, Victoria Park, E.—Pathologist. Salary, £105 per annum. Applications to H. Dudley Ryder, Secretary.

Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C.—Senior House Surgeon. Salary, £100 a year, with board and residence. Applications to the Secretary.

General Hospital, Birmingham.—Two Receiving-Room Officers. Salary, £150 per annum. Applications to Howard J. Collins, House Governor.

Appointments.

De Sylva, E. M. J., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Scalloway District of the county of Shetland.

Foley, Cornelius, L.R.C.P. and S.., L.M.Irel., District Medical Officer by the Ross (Herefordshire) Board of Guardians.

Grandage, William B., M.B., B.C.Cantab., M.R.C.S., L.R.C.P. Lond., Assistant Resident Medical Officer to Queen Charlotte's Lying-in Hospital.

Harvey, Frank, M.R.C.S., L.S.A., District Medical Officer by the St. Columb Major (Cornwall) Board of Guardians.

Henderson, G., M.D.Edin., Certifying Surgeon under the Factory and Workshop Act for the Coldstream District of the county of Berwick.

Imrie, G. J., M.B., M.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Levenwick District of the county of Shetland.

Lavers, Norman, M.D.Brux., M.R.C.S., L.R.C.P.Lond., Physician Superintendent of Bailbrook House, Bath.

Richards, John Barrow Osborne, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer of Health for the Wadebridge (Cornwall) Urban District.

Sharp, P. J., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Ollaberry District of the county of Shetland.

Skinner, D., L.R.C.P. and S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Lauder District of the county of Berwick.

Births.

Caley.—On Sept. 19th, at 24 Upper Berkeley Street, London, the wife of H. A. Caley, M.D., F.R.C.P., of a son.

Marriages.

Chater—Arnaud.—On Sept. 18th, at the Church of St. Thomas à Becket, Portsmouth, Staff-Surgeon Harold John Chater, R.N., second son of William Chater, Esq., of Godalming, Surrey, to Winifred, youngest daughter of Francis Henry Arnaud, Esq., of Southsea, Hants.

Cowie—Roberts.—On Sept. 19th, at St. Stephen's, Bournemouth, Charles George Cowie, M.A., M.D., of Bon-Accord, Branksome Park, son of the late Alexander Cowie, of Ellon, Aberdeen, to Evelyn Gertrude, second daughter of Fred S. Roberts, of Wyuna, Branksome Park, formerly of Melbourne, Australia.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, OCT. 2, 1907. No. 14

NOTES AND COMMENTS.

Climate and Diarrhœa.

IF anyone doubts that temperature and rainfall are intimately related with mortality, at any rate at this time of the year, the returns for last month as they come in should go a good way towards carrying conviction. The death-rate for this cold, showery summer has been noticeably low, the last two weeks of August only showing 11.5 and 11.8 per thousand as the annual rate of mortality for England, and London for the first eleven weeks of the quarter averaged but 12.0. But with the burst of warm, dry weather that the last three weeks of September have seen, the death-rates have begun to mount again. The great saving, of course, has been in the diarrhœal mortality in young children, which has been almost phenomenally low; certainly so as compared with last year's returns. Now, it is a matter for very serious reflection whether, knowing the outstanding facts, it is not possible from them to construct some working theory. The knowledge that the 4-foot earth thermometer is beginning to rise, and that in due course that rise will be followed by a slaughter of the innocents by diarrhœa, is useless pedantry unless it tends in some way to guide useful action in preventing this lamentable result. It may be argued that temperature and climate are "acts of God," and therefore beyond the scope of preventive medicine, but there is no sense in pursuing the paths of preventive medicine unless attempts are made to circumvent the "acts of God." The factors most needed in the situation at the moment are imagination, and the solid wish to confirm or refute the results of imagination.

The Shortcomings of the Fly.

STARTING with the facts that dry heat in summer conduces to diarrhœa, and that cool showery weather prevents it, and taking it for granted that the cause of diarrhœa is bacterial, it seems necessarily to follow that hot, dry weather conduces to the growth and distribution of the particular bacterial agent or agents at work. Now, the only obvious distributing agencies are the movements of the air carrying particles to a distance, and insects. It is quite a plausible explanation that the rain, falling on successive days during a wet season, lays the dust, and that the dissemination of bacteria is thereby restricted; but it is quite as plausible to argue that cold, wet summers are poor in flies, and that it is to flies we ought to look for an explanation. Probably both factors operate to some extent, but which is the more important, is there not enough evidence to decide? This summer has been markedly poor in house-flies, and we feel our suspicions against them much aroused. That flies can carry infection has been demonstrated, and that they do feed on fæcal matter and on food prepared for human consumption indiscriminately, with, perhaps, a slight preference for the former, is a fact of common observation. We have, then, the following links in the chain of evidence:—That flies can carry infection, that they revel in diarrhœal dejecta, that they frequent food stores, that when they are abundant diarrhœa is abundant, and that when they are absent diarrhœa is infrequent. Moreover, in places where middens exist and sewage disposal is slack, diarrhœa and enteric diseases are generally rife. These facts surely would justify a campaign against flies as vigorous as that against mosquitoes.

Homœopathic Spas.

THE homœopaths, or as we see them frequently styled now the homœpathists, have been disporting themselves at Harrogate. A Congress was held at that town towards the end of last month, and the delegates were refreshed by an address from the President on "Spas I have seen." The "allopathic" infidel is perplexed as to the need for spas in the Hahnemann system, but any qualms that might disturb a doubting brother were speedily put to rest by the president's comforting words. "At first sight," said he, "it might not seem that hydro-therapeutic treatment, either at the spas of Great Britain or on the Continent, have much, if anything, to say to homœopathy. To that he emphatically demurred, because he was of opinion that in the highly varied and luxurious healing founts which nature had caused to flow gently forth from some of the fairest spots on the face of the globe, the alchemy which was connected with the dogma, 'similia similibus curantur,' was distinctly in evidence." "Here's richness," as Mr. Squeers said when he tasted his pupils' milk-and-water. The evidence which supported the alchemy of this dogma was not, as far as we can see, produced; but, then, it is not such an easy task to demonstrate the alchemy connected with a dogma.

Silica in Infinitesimal Doses.

BUT as we read on, we come to even more startling news. "The permanently curative effects of many of these waters, he believed, lay, not so much in the massive doses of the more ordinary salts which they contained, as in the almost infinitesimal quantities of deeply-acting drugs, like bromine, iodine, silica, and arsenic, which also existed in some of them, and very small doses of which we knew perfectly well had a potent and lasting action on the constitution when administered in the dilutions prepared by the chemist. The knowledge of how to use these healing streams was a valuable addition to their armamentarium." The point raised here by Dr. W. T. P. Wolston, in his address, is a valuable one, and may have missed many men's attention. The opinion he gives amounts to this: that things are not what they seem, and that if a patient goes to a spa after a course of free living, and returns home permanently set up, we must not attribute this restoration to massive doses of magnesium and sodium sulphate, but to the cheering and invigorating effect of the infinitesimal quantities of such "deeply-acting" drugs as silica. In the midst of the material world of medicine, how refreshing it is to have these idealistic conceptions to counteract the hard facts of science and experience!

The "Art and Mystery."

A subsequent speaker at the same Congress made the apposite statement that "homœopathy was like Christianity in one respect—it contained both truth and mystery. That there was truth in it they all knew, and the mystery that attached to it was the mystery that led to everlasting discussion." We do not remember to have heard the homœopathic position stated with quite so much candour before. The great difference between Christianity and homœopathy, we should think, would be that Christianity contained a great deal of truth to a little mystery, while homœopathy contains very little truth to a great deal of mystery—resembles, indeed, Falstaff's hotel bill in containing but "one halfpennyworth of bread to this intolerable deal of sack." But, as the Congress speaker said, it is this mystery which leads to everlasting discussion, and we might add that it is just this "mystery" which attracts a certain class of mind which has not the openness to prefer demonstration to speculation. The beauty of the everlasting discussion that ranges about homœopathy is that, like the disputes of the old schoolman, it can lead to no useful result, and the point at issue remains as obscure and mysterious after the argument is over as when it began.

The Boot on the Other Foot.

The firm known as "Boots, Cash Chemists, Ltd.," which combines the useful art of pharmacy with the vending of trinkets and the circulation of literature, were considerably perturbed the other day by being summoned for the offence of selling tablets containing strychnine without the precautions enjoined by the Pharmacy Act. The offence was proved by the Pharmaceutical Society, who initiated the prosecution, and the defendants fined. By way of justifying themselves, Messrs. Boots proceeded to summons a qualified pharmacist, trading as W. Walter Madden and Madden and Co., for a similar fault, and at Westminster Police Court, on September 23rd, they succeeded in getting a conviction. To the medical man this occurrence suggests several lessons. In the first place, everyone must regret the decline of the old-fashioned pharmaceutical chemist who was in business for himself, had one shop, and personally supervised and was responsible for everything that went on therein. In the second place, there must be equal regret for the unhappy habit that is springing up of indiscriminately selling to the public any drug that is asked for. And, thirdly, it seems that the restrictions of the Pharmacy Acts, little effective as they are, can be easily neglected. Happily, it is still possible for medical men, by recommendation and patronage, to support those pharmaceutical chemists who give their personal attention to their business, and conduct it with a due sense of its grave obligations.

LEADING ARTICLE.

PLURALITY OF HOSPITAL APPOINTMENTS.

The honorary medical staff of the Bristol Infirmary have found themselves suddenly plunged into the throes of a controversy with their Board on questions connected with the terms of their appointment. The issues involved are of the deepest interest to the medical profession generally, and on that ground claim an amount of attention not usually accorded to a local hospital dispute. The crux of the matter may be readily gathered from the two following rules which were last week passed at the half-yearly meeting of the Royal Infirmary Board by about twenty out of seventy-two governors. The new rules provide that: "No member of the honorary staff shall hold any union or club appointment. No member of the full staff shall hold any other professional public appointments other than a professorship or lectureship at any university, college, or school. No member of the assistant staff shall hold any other general hospital appointment, nor more than one special hospital appointment. That the full physicians shall limit their practice to medical work. That the full surgeons shall limit their practice to surgical work. That each of the specialists shall limit his practice to his speciality." The new rules, therefore, involve two points—namely, plurality of appointments and the ethics of consultant and specialist practice. With regard to the first, it is not easy to understand why, in a provincial town like Bristol, the Committee of the Infirmary should take so sudden a stand against plurality. There is a large general hospital, but the posts there are never held in common with those at the infirmary. There are the usual number of small medical charities, general and special, that we would expect to find in a population of some 320,000. Within a generation the ancient city of Bristol has greatly increased in size, probably by one-third. The medical school is one of old standing, and many famous medical men have been connected with the Royal Infirmary at Bristol. Of late years the local school has entered on a new phase of existence by its absorption in the Medical Faculty of the Bristol University. It may be that these altered conditions may demand the framing of fresh ethical rules on the part of the profession and of alterations in the tenure of appointments on the part of the executive boards of the medical charities. The new rules were energetically upheld by the President of the Infirmary, Sir George White, who quoted a series of rules against plural appointments in force at hospitals and infirmaries in Birmingham, Leeds, Liverpool, and Manchester. The populations, and consequently the number of medical charities, however, of those towns vary from 450,000 in Leeds to 650,000 in Manchester, and they can hardly be regarded, therefore, as parallel instances. As regards the general question of multiplicity of hospital appointments, it may be pointed out that there is pluralism and pluralism. There is the tenure of two, or in some cases three, posts that are well within the capacity of a single individual, with work that extends the experience and strengthens the capacity of the holder. Especially true is this of the holding of an appointment in some special branch in addition to a general post as physician or surgeon. In Bristol there seems little chance of any man holding so many posts as to be incompatible with the proper discharge of his duties. Were there any such risk, it would be easier to understand the sudden reversal in the policy of the infirmary, which has hitherto given a free hand to its medical staff to hold what outside posts they wished, and to do consultant, general, or special practice as they chose. As regards the holding of multiple posts by one man who is obviously unable to do his duty in all of them, we hold that kind of pluralist as an anachronism and a hindrance to his profession. His existence handicaps most unfairly the career of many a promising young man, who is thereby prevented from entering the lists. So far as the restricted and wholesome plurality that is likely to obtain in Bristol is concerned, we are absolutely in agreement with the local medical men, who regard the matter as one that concerns themselves alone. We venture to hope that the new rules will be reconsidered by the whole body of governors of the infirmary. At the same time, we suggest that the resolution to restrict the private medical practice with certain conditions should also be reconsidered. During a long and not undistinguished history, the Royal Infirmary has been well and ably served by men who were for the most part frankly engaged in general practice. There is much to be said for a system of that kind, which reduces the doctrines of advanced science to the test of daily and sustained application. In the past, at any rate, Bristol has had no reason to regret the service of her medical charities by medical men engaged in general practice. Whatever the upshot of this new departure on the part of the Royal Infirmary, we trust that the decision will be submitted to the whole body of the governors, and that the views of the local medical profession will be duly considered.

CURRENT TOPICS.

The Beatitude of Bowls.

THE twentieth century has been ushered into existence in the midst of a kind of athletic renaissance among the nations of the earth. Cricket, football, rowing, tennis, cycling, golf, all have their devotees; while recreations demanding varying degrees of strength, skill, and activity are hardly less popular. One of the most recent revivals is the ancient game of bowls, which now bids fair to take once again a leading place among the sports of Merrie England. As a matter of fact, it is just as good a game to-day as it was in the time of Raleigh or in the remote Anglo-Saxon times. While it provides good, easy exercise for the whole body, it requires a moderate amount of skill, without laying too great a strain upon the mind. The whole environment of bowls is restful; its green sward a delight; its battles one long, enthralling beatitude. Not least of all, it is within the power of man, woman, and child to play a fairly good game, although the higher flights demand a level of achievement that is undreamed of save in the house of the serious player. So that it may pretty safely be assumed that bowls will once again take a foremost place amongst our national games. From a medical point of view, we have nothing but praise for this most excellent of recreations. It provides open-air exercise and amusement for old and young, it is admirably fitted for many invalids, and, above all, it is one of the best of what may be called natural opiates.

Scarlet Fever and Sanitary Science.

SCARLET fever still presents an unbroken front to the attacks of the sanitarian. In spite of many years of notification and the enormous sums that have been expended in the hospital isolation of the malady, there is no sign of decrease in its annual incidence upon the nation. Nor is it at all hopeful under present conditions that scarlatina will ever be exterminated by sanitary measures alone. Its short incubation, its high degree of infectiveness, and its proneness to attack infancy and childhood, render it one of the most difficult of all the specific fevers to bring under control. Indeed, the prevalence of scarlet fever in most of our great towns at the present moment is such as to constitute an admitted failure of the measures of public health hitherto organised with a view of controlling and ultimately eradicating the disease. Some day the key to the position may be placed in the hand of medical science, which has solved many problems of no less apparent hopelessness. Take the case of cholera and of small-pox, for instance; one has been banished altogether from our shores, and the other has been reduced to a fractional and feeble existence. On the whole, it seems possible that the future control of scarlet fever may be in the direction of some preventive vaccine or serum. Why should not the Government find the money to carry out an authoritative scientific investigation upon this point? At any rate, it seems clear that our present public health methods in dealing with scarlet fever stand in need of revision.

School Hygiene.

AN important divergence of views has taken place with regard to Dr. George Newman's appointment as Chief Medical Officer to the Education Board. It is held that the post should have gone to Dr. Kerr, of the London County Council. As both these gentlemen are of high position and ability, the matter might seem to be merely a personal one, but this is not the case. The question at issue is really the vitally important one as to whether the administration of hygiene in schools shall take place through the ordinary sanitary machinery of local authorities, or whether school hygiene shall be totally separated from ordinary public health work and managed by a distinct staff. The decision on this point was practically made by the late Government when it did away with school boards and made county councils and municipal authorities responsible for education. Had the old school boards remained, no doubt it would have been comparatively easy to make each authority responsible for the respective interests; but the matter is so complicated now by the fusion of education with municipal affairs, that the distinction of sanitary administration from school hygiene administration would be difficult to maintain. Sir Robert Morant, Permanent Secretary to the Education Board, had apparently decided that the medical inspection of schools should take place through the channels of the departments of the medical officer of health, and therefore the appointment of a medical officer of health, pure and simple, to be head of the medical department of the Education Board was natural, and a sound and well-known man was selected for the post. Whether this policy is the right one is a weighty question which deserves full discussion.

Mental Condition of Rayner.

The view expressed in the Medical Press and Circular at the time of the trial of Horace G. Rayner for the murder of Mr. Whiteley—namely, that the man was not mentally responsible at the time of the crime—has been strikingly confirmed by the latest news from Parkhurst Prison, where he is now incarcerated. It is reported that Rayner is now recognised as being in a hopeless mental condition. His suicidal intention shows no tendency to diminish, and after a probationary period of "observation" he has been classified by the medical staff of the prison as permanently weak-minded. It is no longer considered safe to confine him in a separate cell, even under close observation. He has accordingly been transferred into an "association ward," where a warder and an orderly are in constant attendance. Ever since Rayner's reception at Parkhurst he has been in hospital, and he is likely to remain there until released by death or transferred on certificate to a criminal lunatic asylum.

The Anti-Vivisection Hospital and the Sunday Fund.

That curious product of modern medical evolution, the National Anti-Vivisectionist Hospital at Battersea, is clearly not going to take "lying down" the refusal of the Metropolitan Hospital Sunday Fund to make a grant. Their secretary has been engaged in a fulminating correspondence with Sir E. H. Currie. The latter gentleman has been indiscreet enough to state in reply that the governing body of the Battersea Institution imposes restrictions on its medical staff. The Hospital Sunday Fund, he adds, can in no case assist institutions whose governing body dictates the form of treatment to be used by the medical staff. To that statement the secretary promptly replied, pointing out that, whereas the Homœopathic and the Temperance Hospitals imposed special forms of treatment upon their medical staff, both of them received grants from the Sunday Fund. Logically, the position appears to be unanswerable. A fundamental rule of administration, the first we remember to have heard from the Hospital Sunday Fund, is laid down by a responsible official, but is at once shown to be unequally applied. We have no sympathy with the supporters of the Anti-Vivisectionist Hospital authorities; on the contrary, we regard their views as narrow, illogical, and ludicrously disingenuous, but nevertheless we think that institution is entitled to fair treatment. If they are excluded from a grant by a law that is only applied in particular instances, then they are unjustly dealt with. The weak point seems to be the want of a declared policy by the Metropolitan Hospital Sunday Fund, which is now enabled to inflict a serious injury upon a medical charity by withholding a grant on grounds that are, as a rule, autocratic and absolutely secret.

The "Fainting Fit" in Criminal Assault.

Of all classes of criminal inquiry, there is none that should be approached with more caution and calm judicial alertness than that which deals with sexual charges. The very fact that such cases are generally heard *in camerâ* renders paramount the necessity of an absolutely impartial administration of justice. The criminal assault, by the very circumstances of the case, furnishes a readily available instrument to the hand of the blackmailer. Short of that, it suggests itself automatically, as it were, to the disturbed imagination of the hysterical or the epileptic woman, who often believes implicitly in the reality of her imaginings. Again and again the apparent sincerity of her evidence may convince a seasoned court of justice. Members of the medical profession are always specially open to the charges of blackmailers or of hysterical women. Only last week a medical practitioner in the East of London was tried at the Central Criminal Court on a charge of assault on a young married woman. In her evidence she stated that, being subject to fainting fits, she went into one of them, and on coming to found herself on a sofa and prisoner assaulting her. A "fainting fit" of this kind is of so peculiar a type as to be in the highest degree unlikely and suspicious. As a matter of fact, the judge, acting on the opinion of the jury, very properly dismissed the case.

Medical Officers of Health and Security of Tenure.

The last thing that is likely to be learnt with regard to the origin of many public disputes is the truth of the matter. As regards Southend it has been more than hinted in some quarters that Dr. Nash has been deprived of his post as Medical Officer of Health because of his zeal in public sanitary administration. Whatever may have happened in his particular case, there can be little doubt that the general question as to the permanency of health appointments of that kind is in urgent need of authoritative discussion. Under the present system, as we have for many years past pointed out in the pages of the Medical Press and Circular, the annual election, or the power to dismiss a Medical Officer of Health without the sanction of the Local Government Board, opens the road to many abuses. A competent and zealous official in that capacity must necessarily come more or less into collision with members of the Council which he serves. At every turn he finds himself called upon to criticise his own masters, who as tradesmen, landlords, and so on, are continually brought into contact with the Public Health Acts. A man cannot act satisfactorily as servant and judge upon the councillors; even if he have the will the councillors will take good care that he has not the way—at any rate after the next succeeding election.

Sheffield Infirmary Trouble.

At present the position at Sheffield, from the spectacular point of view at all events, is one of marking time. The Hospital Committee are preparing a scheme for presentation by the Board of Guardians at their next meeting, and the medical men of the district have met and passed resolutions to the effect that they consider the arrangements at present in force unworkable, and that they do not see that they are called upon to take any active steps in the matter. By a curious coincidence, however, two Local Government Board inspectors, Dr. Fuller and Mr. Bagenal, have visited the town and held a consultation with the Hospital Committee. In an inspired paragraph in the *Sheffield Daily Telegraph*, it is stated that this visit had no connection with the dispute in hand, but was connected with a suggested amendment of the Hospital Separation Order, which, it is naïvely asserted, does "indirectly" affect the issue. Moreover, the Hospital Committee, says the paragraph, incidentally informed the inspectors of the new scheme. From the line the Local Government Board has always hitherto taken in matters of this sort, we have little doubt that proper advice was given to the Hospital Committee, and though perhaps the inspectors could not take official cognisance of the embryo proposals, our forecast would be that a deft finger was laid on any objectionable points. If the matter is satisfactorily adjusted, we cannot grumble, perhaps, at the Guardians wishing to save their face.

Register! Register! Register!

The usual appeal has been made by the General Medical Council to members of the medical profession to notify any change of address to the official headquarters at 299, Oxford Street, London, W. In view of the somewhat unbusinesslike character that is often attributed to the profession in question, it may be well to remind any of our readers who may have changed their residence during the year that the omission to notify the same may possibly lead to a removal of that individual's name from the "Register," with the consequent inconvenience and annoyance of such a position. The Registrar also adds, significantly, that much trouble will be saved if the names are written clearly, and the full names, or, at least, the full initials, be also given.

PERSONAL.

Dr. James Craig will deliver an address at the opening meeting of the medical session at the Meath Hospital, Dublin.

A fountain, in memory of Dr. James Wilson, of Govan, was unveiled in that town last week by Mr. Robert Duncan, M.P.

Mr. R. F. Tobin, F.R.C.S., delivered on Tuesday last an address introductory to the medical session at St. Vincent's Hospital, Dublin.

Dr. Reginald Stilwell will entertain the members of the South-Eastern Division of the Medico-Psychological Society for their autumn meeting at Hillingdon.

We beg to congratulate Dr. French of the White Star liner, *Majestic*, on his providential delivery from a murderous attack by a lunatic on the ship.

The International Congress of Hygiene and Demography was opened on the 23rd ult. at Berlin by the President, Prince von Schoenaich-Carolath.

Dr. M. Grabham, representing the Royal College of Physicians of London, gave an address at the centenary of the Geological Society on September 26th.

Dr. F. M. Sandwith, Gresham professor of Medicine, will give the first Hunterian lecture of the Hunterian Society on October 9th, at 8.30 p.m., on "Dysentery."

Dr. A. E. Garrod will open the winter session at the Hospital for Sick Children, Great Ormond Street, London, by a lecture on October 10th on "Diabetes in Children."

Mr. T. Neville, L.R.C.P. and S.I., of Goelen, co. Cork, has been the recipient of a handsome suite of hall furniture on the occasion of his wedding, presented by the inhabitants of Goleen.

Dr. James Rutherford has resigned his post as Medical Superintendent of the Crichton Royal Institution, Dumfries, on the ground of ill-health. Dr. Rutherford has held the post for twenty-four years.

Sir Lauder Brunton has been compelled to undergo an operation in the Royal Victoria Hospital, Montreal, but we are pleased to hear that his homeward journey is not likely to be delayed for more than ten days or so.

Mr. James Carroll, surgeon in the United States Army, has recently died after prolonged suffering, as the result of contracting yellow fever from the bite of a mosquito, which he allowed to bite him for experimental purposes when investigating the disease.

The British delegates to the Berlin Congress for Hygiene included Dr. Whitelegge, C.B., His Majesty's Chief Inspector of Factories and Workshops, and representatives of the War Office, the Admiralty, the Local Government Boards of England and Scotland, and the Board of Education.

Mr. Charles Sissmore Tomes, M.A., F.R.S., F.R.C.S., who delivered the inaugural address of the Manchester Medical School on the 1st of October, is Treasurer of the General Medical Council and Vice-President of the Zoological Society. His subject was "Medicine and its Specialities and the State: a Retrospect and a Prospect."

Dr. W. Hale White will deliver the opening lecture of the winter session of the North-East London Post-Graduate College and of the North-East London Clinical Society to-morrow (Thursday), at 4 p.m., at the Prince of Wales's General Hospital, Tottenham, the subject being "The Various Conditions Causing Enlargement of the Liver." All qualified medical practitioners are invited.

It is stated that the selection committee of the Unionist majority in the Liverpool City Council has unanimously recommended Dr. Richard Caton for election to the position of Lord Mayor of the city for next year. He is a member of the Liverpool University Council and of the General Medical Council.

We are glad to announce that on September 26th Dr. J. M. Rhodes was honoured by a presentation at Didsbury. The presentation took the form of a cheque and an illuminated address, to which there were 250 signatories, and the subscribers to the testimonial included all classes of the community.

The following gentlemen have lately been the recipients of presentations from patients, friends, and institutions they have served for long periods of time. Mr. William Annesley Eden, L.R.C.P. Lond., M.R.C.S.Eng., on the occasion of his leaving Wadebridge (Cornwall); Mr. Frederick Weatherby, M.R.C.S.Eng., L.S.A., J.P., after more than twenty-five years' service to local public institutions at Long Ashton (Somerset); and Mr. Eleazar Davies, L.R.C.P. and S.Ed., at Pantywaun, near Dowlais.

A CLINICAL LECTURE
ON
CONGENITAL ANOMALIES OF THE EYE. (a)

By SYDNEY STEPHENSON, M.B., F.R.C.S.Ed.,

Ophthalmic Surgeon to the Kensington General Hospital, the Evelina Hospital, the North-Eastern Hospital for Children, etc.

(Concluded.)

III.—Anomalies Due to Intra-Uterine Inflammation.

Considerable attention has recently been paid, especially on the Continent, to intra-uterine inflammation and infection as factors in the causation of certain anomalies of the eye. It is, indeed, difficult to account for some conditions, as congenital ophthalmia and congenital staphyloma, on any other grounds.

In the first case, a few words may be said with regard to so-called "congenital ophthalmia," as to the existence of which there can be no shadow of doubt. That babies might be born with ophthalmia is a fact that has been known, although perhaps not generally recognised, for many years. The existence of such cases was alluded to by Quellmalz in 1750. In 1902 Dr. Queirel, a Marseilles obstetrician, whose work apparently has been overlooked by ophthalmic surgeons, reported 15 cases of the kind that he had observed in the course of his work (*Leçons de Clinique Obstétricale*, 1902). I have recently collected from the literature 71 cases of ante-partum ophthalmia, and to that number have been able to add 19 others met with in the course of my own work. The material at hand, therefore, amounts to 105 cases, a number that shows pretty conclusively that this form of disease is nothing like so rare as has been assumed.

In explanation of the cases it has been very generally assumed that the liquor amnii had been discharged long enough before the completion of the second stage of labour to allow of inoculation of the infant's eyes by gonococci or other organisms present in the maternal passages. Assuming that the fluid was really liquor amnii, and not liquid such as is known to be now and then present between amnion and chorion, this premature escape doubtless accounts for a moiety of the cases. It may actually have taken place in 26 of the 71 cases where the time of rupture of the membranes was mentioned. There still remain, however, 63.38 per cent. of the cases in which this view, known as Haussmann's, does not apply. The bacterioscopic examination of the discharge from the eye gives us no help, since the results do not differ markedly from those obtained from ordinary cases of ophthalmia neonatorum. Thus, among my 19 cases, gonococci were present in 52 per cent., pneumococci in 10 per cent., bacterium coli in 5 per cent., B. pyocyaneus in 5 per cent., and the results were negative in 26 per cent. Thanks to the work of Kühne, Haussmann, and recently of Hellendahl (*Beitrage zur Geburtshilfe u. Gynak.*, Band X., Heft 2), there is now experimental evidence to show that penetration of the intact amnion by bacteria is possible. It is known that organisms, especially the gonococcus, may lurk in the recesses of the uterine mucosa, and it seems likely that they may pass through the chorion and amnion, and thus reach the liquor amnii, where they infect the conjunctival sac during the last weeks of pregnancy—that is to say, at a time when the eyelids are no longer closed, as at an earlier period in fœtal life. What is true of the gonococcus is true also of the other micro-organisms found in association with ophthalmia neonatorum. The bacteriological permeability of the membranes once granted, organisms may reach the uterine cavity either from the mother's anus or from the peritoneum *viâ* the Fallopian tubes.

The etiological analogy of ante-partum ophthalmia with the condition in which the liquor amnii is occasionally found to be brownish in colour, muddy in consistence, and peculiarly offensive to the sense of smell, is somewhat striking. The fluid in these cases may be likened to an ordinary typhoid stool. Indeed, the two conditions—ophthalmia and offensive liquor amnii—have been known to co-exist, as in cases reported by Chavanne (*Rev. Générale d'Ophtalmologie*, 1899, p. 70), and by Armaignac (*Annales d'Oculistique*, 1902, T. 128, p. 241). Dr. Handfield-Jones has recently published (*Journ. of Obstet. and Gyn of the British Empire*, April, 1907, p. 305) five of these cases observed among 3,300 deliveries at the British Lying-In Hospital, London. In one case, examined bacteriologically, the stinking liquor amnii was found to contain staphylococci and coliform bacilli. Handfield-Jones thinks that if infection with the coliform bacillus occurred after rupture of the membranes, then the putrefactive changes must have supervened with preternatural rapidity. In one of his cases, however, the amniotic fluid was noted to be muddy and offensive at the time the membranes ruptured.

The etiology of ante-partum ophthalmia has been discussed at some length, because it forms an authentic and comparatively simple instance of intra-uterine infection, and renders it more easy to understand what may occur in other cases believed to be due to the same cause, such as congenital adherent leucoma and staphyloma, and dacryocystitis, and opacities of the cornea, and the rare and curious conditions called "cryptophthalmia" and "buphthalmia."

Congenital Staphyloma.—This rare condition, of which only about twenty cases have yet been published, is almost certainly due to perforation of the fœtal cornea, as the result of intra-uterine inflammation. This view has been strongly urged in an important communication on the subject by Mr. J. H. Parsons (*Trans. Ophthalmological Society*, Vol. XXIV., 1904, p. 47), who bases his opinion to a large extent upon the histological appearances presented by such an eyeball removed from a child aged three days. As Parsons points out, "All these cases of anterior staphyloma show exactly the same features as those found when the condition develops in the usual manner after birth." "*A priori*, therefore," he continues, "we should naturally be inclined to attribute them to the same cause." The considerations that apply to congenital staphyloma apply equally to an even rarer condition—namely, *congenital leucoma adherens*—that is to say, a corneal cicatrix to the hinder surface of which the iris is adherent.

Congenital Dacrocystitis.—Although, as explained before, the essential cause of this condition is undoubtedly of a developmental nature, yet when a baby is born suffering from a suppurating or distended lacrymal sac—from a lacrymal abscess, in fact—the infection must have taken place prior to birth. The organisms present in such cases are the pneumococcus, the bacillus coli, the common pyococci, and the xerosis bacilli, of which all, with the possible exception of the xerosis bacillus, have been found in the genital tract of parturient and puerperal women. It is probable that in these cases, as in many of congenital ophthalmia, the micro-organisms gain access to the epithelial *débris* of the lacrymal passages by passing through the unbroken fœtal membranes, and that they reach the cavity of the uterus either by ascending from the pudenda or by descending by the Fallopian tubes.

Congenital Opacities of the Cornea.—In rare cases a child is born with a more or less cloudy cornea. These cases must be carefully differentiated from those of buphthalmia, or infantile glaucoma, concerning which something will be said later. The main points of distinction are—first, that the intra-ocular tension is raised in buphthalmia, and, secondly, that the cornea in that disease is not only cloudy, but more strongly curved and larger than normal. Congenital opacities of the cornea may be total or partial, and the opacity may be complete or incomplete. The "sclerophthalmia" is applied to cases where there exists no sharp boundary line between the sclera and the cornea, which run almost imperceptibly into one another. The "arcus juvenilis" of Wilde is a condition closely resembling the arcus senilis, but of congenital origin. A good example of this condition has been described by Mr. R. W. Doyne and myself in the twenty-fourth volume of the *Transactions* of the Ophthalmological Society (1904). It should be added that many authorities still believe that corneal opacities are the result, not of intra-uterine inflammation, but of incomplete development. The fact that they tend to clear after birth does not tell strongly in either direction. Opacities due to injury at birth, so carefully described by Drs. Ernest Thomson and Leslie Buchanan, belong, of course, to quite a different category.

(a) A Clinical Lecture delivered July 19th, 1907, in the Post-Graduate Course of Ophthalmology in the University of Oxford.

Cryptophthalmia.—This exceedingly rare malformation, of which about a dozen cases only have been reported, is marked by the absence of eyelids, so that the integument stretches uninterruptedly from the forehead over the rudimentary eyeball to the cheek. Indications of the palpebral fissure may be wholly absent, or may manifest themselves by a horizontal furrow or by an anus-like opening. The eyebrows may be absent. The globe, which is always deformed, can be felt under its cutaneous investment as a rounded mass, varying in size from a pea to a cherry. The rudimentary eyeball, however, has reacted to light in some of the reported cases. Thus, in one of bilateral cryptophthalmia recently published by Goldzieher (*Centralbl. f. prak. Augenheilkunde*, Aug., 1903), twitching was noticed when a strong ray of light was allowed to fall on the bridge of skin which covered the eyes. The condition is generally bilateral. Associated ocular defects are the rule. Goldzieher (*loco citato*) believes that intra-uterine inflammation must lie at the root of the changes in the eyeball in cryptophthalmia, inasmuch as no arrest of development could account for the cicatricial tissue and adhesions that have been found in these cases. He supposes that when the conjunctival sac is forming, say, before the third month of fœtal life, an ulcerative process destroys the superficial tissues of the eyeball, whereby a considerable loss of substance ensues, which leads to adhesion between the raw surfaces and the skin covering them. In consequence of these adhesions, the formation of the conjunctival sac ceases. Inasmuch as the cornea has, so to speak, come to grief, the organs of the lid fail to develop, such as tarsus, glands, and cilia. Moreover, the embryological impetus to the separation of the adherent lids is wanting. This view, according to Goldzieher, fully explains not only the absence of lids, but also the undifferentiated condition of the skin-covering in cases of cryptophthalmia (for abstract of Goldzieher's important communication see *Ophthalmoscope*, Vol. II., 1904, p. 135). On the other hand, Van Duyse adopts the theory of amniotic adhesions to explain the production of cryptophthalmia. Lastly, defective development has been invoked by some authors as the cause of this rare malformation.

Buphthalmia, or Infantile Glaucoma.—The last but by no means the least important condition to be described is that curious and rare affection variously known as buphthalmia, hydrophthalmia, megalocornea, and infantile or congenital glaucoma. In a pronounced case the appearances are so characteristic that once seen they can never be forgotten. Thus, one—or more commonly, both—eyeballs are much larger than usual in babies, the corneæ are generally more or less opaque (milky-looking), and obviously globular, and the intra-ocular tension is notably raised. The anterior chamber is deep, the iris and the lens may be tremulous, and a glaucomatous excavation of the optic disc may be found if ophthalmoscopic examination be possible. A degree of photophobia is commonly present. The eyes, as a rule, are myopic. In all the early cases I have myself seen, more or less sight was present. But if the disease cannot be checked by treatment, it is apt to entail blindness. A few instances of spontaneous cure, however, may be found in the literature. The progressive enlargement of the eyeball may lead to the production of rents, resembling supplementary pupils, in the iris, as in one of my cases, to clefts in Descemet's membrane, as in another, to dislocation of the crystalline lens, and to intra-ocular hæmorrhages.

With regard to the etiology of buphthalmia, there exists considerable divergence of opinion. Everybody agrees that enlargement of the affected eyeball is the direct result of intra-ocular pressure acting upon parts which are as yet extensile and yielding. It is further admitted that the pathological feature of these cases is to be found in the existence of adhesions between the periphery of the iris and of the cornea, which impede the exit of fluid from the eye, and thereby lead to heightened intra-ocular pressure (Cross). The point at issue is with regard to the cause of these anterior synechiæ, for that is what they really are. In the year 1889 Horner expressed the view that they represented developmental anomalies. It is held by Mr. E. T. Collins (Norris and Oliver's *System of Diseases of the Eye*, 1897, Vol. I., p. 424) that they result from "a failure in the separation of the anterior fibro-vascular sheath from the back of the cornea." It is clear that such adhesions would prevent the passage of the intra-ocular fluids into the spaces of Fontana, and also that as the eyeball enlarged, the adhesions might yield, thus accounting for the cases of spontaneous cure of buphthalmia. On the other hand, as I have pointed out elsewhere (*British Journal of Children's Diseases*, 1905), most of the cases of buphthalmia that have come under my care have very obviously been the subjects of congenital syphilis. This observation has led me to suggest that the synechiæ, so far from being a developmental anomaly, are attributable to an intra-uterine irido-cyclitis of specific origin. As a point telling in favour of my view, I may say that I have on several occasions seen cases yield to prolonged treatment with mercury and chalk. The histological appearances of buphthalmic eyes are, to my mind, more characteristic of inflammation than of developmental defects. For example, the iris is fibrotic, and the ciliary body often shows evidences of former inflammation; the peripheral parts of the cornea, besides being attenuated, may be infiltrated with cells and permeated by fine vessels. These changes, I admit, might possibly be of secondary production, but I believe the evidence points rather in the direction of their being primary and the essential cause of infantile glaucoma. In my experience, the fact that buphthalmia is seldom associated with other anomalies, unless it be with plexiform neuroma, tells in the same direction. Reis (v. Graefe's *Archiv für Ophthalmologie*, LX., Heft i., 1905) and others have attached importance to the fact that in these cases the canal of Schlemm is more or less obstructed, if not actually absent, as a congenital defect. Obliteration of the venous channels, however, could come about as the result of anterior synechiæ, much as it is known to supervene in old cases of glaucoma in the adult (Parsons).

Microphthalmia and Anophthalmia.—The two conditions of microphthalmia—that is, an abnormally small eyeball—and anophthalmia—that is, an absence of the eyeball—have been placed in a separate category because of the divergence of opinion as to their causation among those most competent to express an opinion. There are some, as Hess, who adopt the developmental theory, and others, as Deutschmann, who voice the inflammatory theory. It is sometimes difficult or impossible to say where microphthalmia ends and anophthalmia begins. We shall do well, I think, to adopt the view enunciated by Messrs. Collins and Parsons (*Trans. Ophthalmological Society*, Vol. XXIII., 1903, p. 244), which is to the effect that no case should be classed as one of anophthalmia if on microscopical examination the least trace can be found in the orbit of retina, optic nerve, or, indeed, of any part of the nervous apparatus of the eye. All other cases, no matter how insignificant and functionally useless the eyeball may be, are examples of microphthalmia. It is a little unfortunate, from a practical point of view, that this scientific distinction between the two conditions can be established with certainty only by a more or less difficult microscopical investigation.

Of *anophthalmia,* as defined above, I have never seen a case. When the defect does occur, which must be very rarely, it seems always to be associated with grave developmental deficiencies in the central nervous system, such as absence of cranial nerves, of olfactory lobes, of optic chiasm or tract, or of the external geniculate body. On the other hand, *microphthalmia,* especially in its slighter forms, is tolerably common. A difficulty in diagnosis can arise only in pronounced cases. Under such circumstances the palpebral fissure is unusually short, and no trace of an eyeball is to be seen on superficial examination. At most, a globular body, of hard consistence, perhaps no bigger than a pea, is to be felt at the back of the orbit on deep palpation through the upper eyelid. Such an examination in the case of a young child is best made under the influence of a general anæsthetic. Even then, when the little finger is introduced into the conjunctival sac, it may be difficult to affirm the absence of a rudimentary eyeball, owing to the smallness of the palpebral aperture. In another and very interesting class of case, the apparent absence of eyeball is associated with a fluctuating cyst in the lower or (much more rarely) in the upper eyelid. Such cases are spoken of as "microphthalmia with orbital cyst." The cystic growth is then by far the most prominent feature of the case. It has been shown by Ewetzky, Lang, Collins, and others that the cyst, in the walls of which retinal elements can often be recognised with the microscope, communicates with a rudimentary eyeball at the back of the orbit by means of a tubular process, also lined with retinal elements. In explanation of this curious condition, it is supposed that the fœtal ocular cleft is closed by adventitious tissue, which eventually bulges out into a cyst, one effect of which is to retard seriously the proper development of the eyeball. Into other theories of causation, such as those which are associated with the names of Kundrat and Ginsberg respectively, we need not enter here.

CONCLUSION.

In conclusion, let me say that I am painfully aware of the shortcomings of this lecture, in which a few only of the congenital anomalies of the eye and its appendages have been described. Several other conditions of at least equal interest, such as albinism, cataract, and anomalies of the fundus oculi, have been omitted. For an account of these and of other anomalies I feel I cannot do better than to refer you to some of the larger text-books on the eye, among which I would signal out for special mention Fuchs' *Ophthalmology* and Parsons' *Pathology*. For anomalies of the fundus it is impossible to praise too highly Frost's *Ophthalmoscopic Atlas* (1896).

NOTE.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Robert Saundby, M.D.Edin., Hon. LL.D., Hon. M.Sc., F.R.C.P.Lond., Professor of Medicine in the University, and Senior Physician to the General Hospital, Birmingham. Subject: "The Sphygmomanometer in Medicine."***

ORIGINAL PAPERS.

"RES MEDICA, RES PUBLICA."

THE PROFESSION OF MEDICINE—ITS FUTURE WORK AND WAGE. (a)

BY WILLIAM EWART, M.D., Cantab, F.R.C.P.

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THE PROFESSION AND ITS TWENTIETH CENTURY CRISIS.

I MAY put to you briefly as general propositions the views I have to express. Although the laity has much to discover in this constellation of ours, we are being a little better focussed and better understood. The sign of the profession is in the ascendant, and everything points to its gravitating into the orbit of the State. At the same time strange perturbations are noticeable within it, and to these I have to call your attention under the name of our twentieth century crisis.

Looking back, there is no profession of greater antiquity, yet none so truly young. The history of humanity is our history, and its future our future. Their joint record can be but beginning. Are we not still fighting for dear life against deadly foes? Ages ago it was the mammoth. Now the microbe only remains; but its days are numbered, and the era of health with its peaceful developments is in sight. The profession is only just cutting its back teeth, in the weirdness of puberty.

Had a man stepped forth in ancient Greece or Rome equal in wonders to the youngest of our qualified men he would have been accounted a demigod. We have thirty thousand such in the kingdom, and they pass unnoticed, as a negligible quantity. But a body controlling so much power cannot remain a cipher. We need only look back little more than a century, as the whole change has occurred in that time. Its wage, its status, and alas! its routine, have remained what they were. But a transformation has been silently accomplished within it. It held the shadow of knowledge; it now holds the substance. It had laboured long in hopeless efforts to be of use; it now waits upon humanity with the most brilliant service. Yet it ingloriously remains "Cinderella," the humble maid of all work.

The Profession—What is it? What ought it to be? What is it going to be?—The question has been asked before; but never with so much point or greater uncertainty. As the moulding of its future is to be partly within your own hands. you must bear in mind its attributes. The famous motto, *Liberty, Equality, Fraternity,* which has proved elsewhere not at all a good fit, would almost seem to have been borrowed from us, for we truly own those characteristics.

Fraternity ranks first: the telling title of "confrères" will identify us anywhere as members of *the* profession. It implies our essential independence and equality, and the absence of any hierarchy among us beyond that of elder brotherhood; and it also suggests the reciprocity without which the profession cannot subsist.

Freedom must ever remain our boast. But complete independence from the State is no longer for us a condition of existence as in darker ages. Independence was then vital to the progress of science. Our need is now no longer for the liberty but for the means of research.

Equality and its Duties.—Our equality is not a mere sentiment: it has its responsibilities. We are not so narrow-minded as to be intolerant of superiority, or anxious to level down the taller heads. We would rather be illogical, and put up with inequalities such as a Harvey, or a Laennec, or a Lister. But for the body of the profession we stand for equality:—Equality in education, equality in qualification, equality in status, and equality in wage. Only this carries with it serious obligations: henceforth but one set of standards, *the highest*. Our equality is that of an education which levels us all up, and of a qualification which confers upon us a high status; and there should never be any falling back in respect of outward dignity or of that within from that high level reached during our fellow studentship, which our life's labour should only further raise.

Altruism.—But there is another attribute, quite unique, which no one has ever been tempted to steal from us. Call it a fault or call it a virtue, we must agree to live with it because it is constitutional but very awkward to bear and delicate to touch upon; a thing to be proud of like an honourable scar, yet carefully concealed; and the disguise invented as a veil is that puzzle of the laity—"professional etiquette." We cannot quarrel with our altruism, which is our chief distinction. But as it is at the bottom of our crisis, and as we cannot subsist on hard work and a proud title, plain common sense must be brought to bear.

THE CRISIS IN ITS TWO ASPECTS—ECONOMICAL AND PROFESSIONAL.

We are in the throes of a double crisis: an

(a) An Inaugural Address delivered, at St. George's Hospital on October 1st, 1907.

economical crisis which affects a large majority of our numbers, and a *professional crisis* which threatens a previously compact profession in its corporate capacity. The situation itself and its great factors are entirely new. The earliest symptoms were overlooked and subsequently misunderstood. They were treated symptomatically without any reference to their cause; and the same symptomatic treatment runs risk of being repeated, as fresh symptoms continue to break out in connection with the individual and with the profession. As both crises have identical and reciprocating causes no separate remedy can exist for either, and any drastic measures would be dangerous if one-sided.

Before we can attempt to legislate for the future we must grasp the inevitably progressive nature of our changes. The chief cause of the economic crisis is our immensely growing success in reducing the prevalence of disease. That which mainly constitutes our professional crisis is the unlimited growth of specialism as the penalty of our progress: we have got in some way to fit it in, or we must fit in with it. The third, which takes effect in both directions, is the headlong change in the times, with which our old routine is quite out of touch. But we also have to take a clear view of the conditions as they now exist within the profession itself.

The Present State of the Profession.—What is the profession? And where is it? It is becoming increasingly difficult to be definite in speaking of the profession as a whole; and hardly any general remarks can apply with equal point all round. Yet, as the laity look upon us as a definite entity, we must shape the argument upon their concrete view, and use the word as a conventional formula for that which to us is really a huge abstraction. What are the facts?

"Pure medicine" and "pure surgery" are both dwindling by chronic cleavage. The great section of "pure surgery" rejoices in exceptional activity and in the absence of any grudge, whether from the body of the profession or the public. Moreover, thanks to the ever-increasing risks to life and limb from the harnessing of the forces of nature, it will continue to be in some request apart from the prevalence of disease. But "pure medicine" is left as severely alone as possible by both. In like manner most of the surgical sub-specialities are in work; but the medical preserves are shot over from every quarter without much regard for any genuine title to the ground. It thus happens that, though the long and gratuitous labour of research is mainly borne by the medical section, they are not as welcome as the quack to a meagre retribution for its fruits; whilst the surgeons are allowed by a public eager to be operated a fair acknowledgment for the time and skill they more largely devote to practice.

There remains the vast body of general practitioners, the bone and sinew of the profession, more homogeneous through the pervading similarity of their avocations, but more isolated by their exacting duties from professional intercourse even in towns. But within recent years a great and hopeful beginning has been made, thanks to the energy of a select few in their number, and to the devoted efforts of the officials representing the British Medical Association throughout the Empire, which should end eventually in the personal participation of all or of a large majority in the organisation which has been elaborated for them. Within that body the disparities are considerable, the great changes which have been gradually worked upon the profession having told unevenly in the direction of increased labour, technical, professional, and charitable, and of diminished emolument. But an adequate living wage is the exception; whilst the worst predicaments are too serious to be further endured.

This complex and strained machine of our profession needs expert handling to save it from being wrecked. None of our specialities, even the most scientific, can be taken as fair exponents of the requirements of the whole. On the other hand, even a complete combination of all general practitioners could hardly be expected to negotiate the affairs and fight the battles of a profession in which specialism is taking, in respect of remunerated practice, but particularly of study and of discovery, so considerable and increasing a part. Moreover, all groups alike have had practically to resign the technicalities of "research"—that latest and tallest of our branches which alone can give our full height when it comes to "sizing up" the profession.

Thus, whilst general practice offers the least of limitations, we look in vain for "the profession" as a concrete and complete working unit. Yet that unit is not altogether a myth. I had almost left out our better part, our students. In our fragmentation the great bond of union remains for us our joint study of man, and in this they are our living link. Perish the thought of any "specialisations" within their curriculum, which, when combined with an equally complete general education, alone now reflects the comprehensive nature of that study, and is the only stage at which there is any complete integration of the profession and of its objects, without difference or distinction between the workers.

The Professional Crisis.—The extensive field of specialism must continue to grow. Does this read practical dismemberment through divided interests, and the end of our influence as a great fighting unit? Is it with us "*Finis Poloniæ*"? That prospect is before us unless we can provide some timely cementation, for the safety of the profession and of specialism itself. Some of the risks of the latter are obvious enough. They have not hitherto included the struggle for existence, though this might easily eventuate in some of them.

The Economic Crisis.—The field of general practice has been for many years contracting, and is bound further to contract. The doctors are too many, the patients too few. In short, there are not enough cases "to go round." At the present accelerated rate of prevention there will soon be little left of preventible disease to attend. And no royalty can be raised on the independent employment of any device of such startling simplicity as the free use of water and boracic powder to fresh wounds to prevent inflammation, or "open air" in a tent with plenty of good food for the treatment of consumption, for that is the kind of *ridiculus mus* for which mountains of research had laboured so long without any compensation.

The altered conditions of life must tell upon local practice whether in town or country. Sentiment still pleads for the devoted family practitioner. But these days are "matter-of-fact": and no man can in the future regard the personal allegiance of those who consult him as a reliable source of income. Nevertheless, in the wealthy districts there must always remain in spite of all drawbacks a fair opening for local practitioners if only their number could be limited.

Less precarious perhaps is the practitioner's hold on the humbler class of practice, particularly under the provident system. But this has given rise to crying abuses under which he is still the sufferer.

Owing to the increasing size of our great towns entire districts are tenanted by a population little removed from destitution, in the service of which his ministrations, not less valuable, not less faithful, not less honourable than elsewhere, lead neither to honour nor to a compensation compatible with the dignity of the profession. That is our sorrow.

What is the upshot? Let me quote from the *British Medical Journal* for September 7th and 14th:—

"The average income of the British practitioner has been variously estimated at £200 to £250 a year. . . . The chances of being able to save even to the extent of the return of the capital expended in education are in a large proportion of cases slight; while reasonable provision for old age, after family expenses are met, is difficult and too often impossible." Is this the wage of lifelong self-sacrifice and of the highest skill?

The odium of so great a reproach has not been truly our own; but we should make it ours were we to fail to concentrate upon its cure the entire strength of our united body, and for that purpose alone, if for no other, we need a compact profession.

The Causes of the Crisis.

To dispel any doubt as to the permanent character of the changes it is enough to enumerate their causes.

The prime cause is the spread of that old tree of knowledge of good and evil. The immediate causes are its fruits, chiefly of 19th century growth. First on the side of the laity:—

1. The vulgarisation of facts and fallacies by our irresponsible Press.
2. The genuine growth of education, particularly in science.
3. The resulting *free thinking and liberty of conscience* in matters medical.
4. The independent individual inquiry for specialism on the one hand: and on the other—
5. The recrudescence of the innate fascination for *home treatment*—no longer with simples, but with compressed remedies.
6. *The emancipation of the patient* which sums up these tendencies.
7. The reversion to *Nomadism* or a wandering life—with all its good and all its evil—a taste fostered by the enormous growth of rapid locomotion.
8. Nomadic restlessness and instability, as it affects the conditions of practice.
9. *The decline of invalidism*, as a result of "open air" and of an active life.
10. The promotion of health by the remarkable spread of physical hygiene, particularly among women.
11. The salutary influence of the growing moderation in the use of alcohol.

Much of all this is the harvest which we have sown. Much more remains which can only be described as the direct handiwork of the profession:—

1. The increasing knowledge of the nature of disease; of its treatment; and of its prevention.
2. The suppression of many decimating infectious diseases.
3. The surgical cure of many intractable chronic ailments;
4. The inevitable specialisation of the study of disease;
5. The progressive growth of specialism in practice; and
6. The attractions exercised by the success of specialists, which tends to swell and overcrowd our ranks.

All these are new facts in the history of the world. Can we pretend to arrest their progressive development? If not, is it likely that the new situation can be met by anything short of a new departure on our part?

THE HARVARD "POLICY OF PERFECTION."

What is the forecast? Is our crisis the herald of recovery—and not the beginning of a natural death for want of anything more to cure? If any doubt should exist we need only look where coming events cast strong shadows before. Twelve months ago this school was represented at Boston by your delegate, at the inauguration of the new Harvard Medical College by the illustrious President, C. W. Eliot; a climax to similar achievements at New York, Baltimore, Chicago, and other great cities in the United States, as well as at the Universities of Toronto, Montreal, and Winnipeg in the Dominion of Canada. They all proclaim what the New World thinks of the prospects of medicine.

The new "Temple of Science"—for no other word could express its magnificence—stands as a sign of the times and a symbol of a principle with which the name of Harvard may deservedly be connected: "To science the highest place in medicine; to medicine the highest place in science."

The Harvard policy of *high standards*, not less consistently pursued for the preliminary than for the professional education, bears witness that medicine is still young, its advance only beginning, and its efficient function marked out among the institutions of the younger countries as of supreme concern to the community. This will be more clearly seen as we inquire into the public aspect of our calling and of our work.

THE STATE AND THE PROFESSION.

(A) THE VALUE OF THE PROFESSION IN THE STATE.

(1) *The Conservative Function.*—What is the profession in the State? Not, as the *Tiers Etat* claimed to be, "*Everything*"—the last of its conceivable errors would be Socialism—but much more than is commonly suspected. Above all conservative, and above all progressive, its antiquity and stability are not merely ornamental, but columns of support for our institutions. Its conservatism, copied from the teachings of Nature, spreads as a lesson which our time is least fitted to supply. Our own unhalting progress is equally safe from the spirit of reaction, and from that of revolution. Even under mob rule we could feel secure; for it is something to be so poor as not to invite spoliation; it is much more to be so skilled as to be indispensable. In reality we stand as the political body whose fabric shows least signs of "rocking," and of which can confidently be said in sight of impending changes, *impavidam ferient.*

(2) *The Function of Progress.*—No less precious than this staying function is our perpetual youth with its immense working power. When humanity shall have passed through its era of disease our function of progress will stand better revealed, in the promotion of its highest physical, intellectual and moral development. Potentially it is so now, to the knowledge of the better informed.

(3) *The Educational Function.*—Faust could not have lived within the last 150 years, or he would not have included medicine in his catalogue of barren studies.

Our students and their labours are a wealth in the State. Their arduous curriculum has often proved a stepping stone to distinction in other careers. Its wide and practical training is worth taking for its own sake, apart from any idea of practice; and it may be begun quite early without any fear of eventual waste of the labour bestowed in this direction. For the community the educational value of the profession will continue to rise with the growth of its higher specialities of research.

(4) *The Advisory Function.*—There are few questions relating to the welfare of the race, besides the social question itself, in which its deliberate opinion would not be the most important of all opinions to ascertain. There is none within its immediate competence greater than that of national education. Where else can be found the expert knowledge of cerebral physiology and pathology to adjust the increasing intellectual burden to the growth of the physical capabilities of the child? A service hitherto uninvited, which the profession will in the future be required to render to the State.

(5) *The Political Function.*—For the exercise of this function it has no longing. Intolerant only of error, it can never surrender its conscience to party, and must remain above the arena. But in any future political redistribution its integrity of purpose and disinterested benevolence may count; and duties will attach to the power which it owes to knowledge and to highly trained aptitudes. Its legislative fitness is displayed in the important growing sphere of medical politics. Lastly, the contingent of able and highly educated women which has of late years joined its ranks is an accession of consultative efficiency, as this completes its practical representation of the entire interests of humanity, man, woman, and child.

(B) THE VALUE CONTRIBUTED TO THE STATE.

(1) *Do ut des.*—In all ages the profession had contributed service for which it had earned various recognition, as priests of Hygieia at Cos, and as Greek slaves at Rome. But never before Jenner had it contributed actual value. The fact is startling, yet true, that whilst there is no profession but this handing to the State immense treasure year by year, if this be merely computed as wage earning value on the human life saved, all other professions have State subvention, establishment or endowment, to say nothing of other rewards that fall to their lot. Alone, the profession of medicine, the all-giving, is not assisted, not even with the education for the supply of that wealth.

In India, 5,000,000 of our fellow subjects have perished of the plague in the last seven years, in spite of the labour lavished by our profession upon the study of its treatment and prevention. The day will come when we shall succeed in abolishing forever that ghastly toll. What reward will this profession receive for the labour of its sons?

In the light of past experience shall we call it again "nothing," as in the other big transactions headed smallpox, typhus and cholera, diphtheria and phthisis, and tropical malaria? "Nothing," not even the out-of-pocket expenses for the means of research. The profession labours and gives; the State takes—where is the "*do ut des*"?

Again, the incalculable value of the disablement from work now largely saved by preventive hygiene is an unacknowledged gift, not of any surplus of wealth, but of the actual means of livelihood of the giver.

But this is not all. Preventive pathology is becoming a definite speciality; and the profession will consist soon of two uneven sections, that of "practice" and that of "research." The latter works for the gain of the State and against that of the profession. To suggest that its support should be charged to the profession would be neither common sense nor common justice. As a branch of national defence it contributes immense value, and has a higher claim to national subvention than the King's forces, which contribute nothing and cost so much. All this makes up a heavy debt, with but meagre instalments on the other side of the account.

(2) *The Nation's Vicarious Charity.*—Not less gigantic is the contribution received by the State from the great branch of practice, in the shape of unrequited or ill-requited service to the community. The "Nation's almoners" is the only title which could express the mission of many of our number in the poorer districts. If anything could be more pathetic than the rags of the apothecary in Romeo and Juliet it is that quiet devotion of the surgeon of twentieth century attainments, as he toils under his heavy burden either totally unpaid, or at a wage not presentable. Innocent of causing the poverty which he attends, a heavy toll of overwork with underpay is systematically levied upon him, which, strange to say, does not relieve him of the poor-tax or of calls for the support of many charities.

Our profession never did admit, and the State never dare admit, that there should be any distinction between the treatment of the poor and the treatment of the rich. Justice then would claim not less but better pay for the appalling labour of ministering to the poor. It was Locock, so says tradition, who replied to the august visitor who summoned him to the bedside of the great Queen, "Her Majesty shall be treated as well as the most humble of her subjects." That great lesson has passed unheeded. The humblest have continued to be treated as queens, but for what honorarium! From the purely moral standpoint of "virtue its own reward" a double wage might be said to have been won, as humility and self-humiliation have been as conspicuous as charity. But these are virtues for individuals to practise apart from their profession. Upon the profession itself their exercise is deleterious and demoralising.

The State which ignores sentiment or pure charity as motives has to answer for the health of the masses; it cannot escape from that law. As regards the pauper class, the liability has been acknowledged; and for that section of its health insurance the public pays the whole because the pauper can pay nothing; but for the vaster insurance of millions who can afford only totally inadequate compensation it pays nothing at all. An immense burden belonging to the State is shifted on to the shoulders of its hard-ground almoners. But no record is kept of the transfer, nor any voucher given to show that business has been transacted for the State.

For the unofficial press the whole transaction goes under the simple heading, "Charity and Charitable Work." From society more of contempt is earned than of pity by the toiler of the slums. It is not perceived that charity is being done for the Nation—*vicarious charity*—and therefore done unto the Nation itself.

(c) The Duty of the State.

Sanitas Sanitatum et Omnia Sanitas.

The profession have hardly realised, much less the laity, that, with the acknowledgment by statesmen that the health of the people is the primary care of the State, a turning point was reached. That principle places the profession in an entirely different position, as on examination a great deal of its work is work done for the State; and it is inevitable that the profession should become more and more its servant. As the organisation of the public health service has brought the new principle into operation, the system cannot remain limited, but must ultimately reach its normal development. This involves definite consequences—under the general headings of the duties of the State, and of the rights of the profession. The functions of the latter, its status, and its pay must tend to be regarded more and more as matters of public utility.

It is manifest then that the quality of our professional work is not a matter of indifference to the State which absorbs it so freely. Good work is said never to be wasted—a comforting view, as the less our labours have profited us, the more certainly must they have been of some use elsewhere—but, as it is bad economy to spoil the quality of good work by breaking the spirit of the worker, our legitimate requirements are not foreign to public utility. They will be appreciably furthered by the fulfilment of the duties to which the State is pledged by its own policy:—(1) The organisation of the prevention of disease and of the cultivation of health; and (2) the organisation of research for both those objects. The nature of the measures required is not open to question: a State examination to ensure the highest efficiency; and a ministry of public health to undertake vast responsibilities too long officially ignored.

Our Remedies and Practical Ideals.

Quality versus Quantity.—Relief cannot be obtained from any source immediately, but would come with least delay and with coupled honour and efficiency from *restricting our numbers* by adding to the labour of our apprenticeship, and to the quality of our work. These are not features of trade unionism—a policy with which we have little in common. They are principles of duty and of progress, and practical applications of the rules of political economy, for the profit of the employer as well as the employed.

The problem of the attendance on the poorer classes and of its proper remuneration is difficult. But why should it be insolvable, with the co-operation of our employers and of the State? In this matter the word *impossible* should have no application, for of all unpractical suggestions, the worst were to submit to a continuance of the present plight of a noble profession.

Our Future Work and Wage.

I believe that in fairy tales the fairy rarely gets any thanks. For the fairy "Medicine" the chief thanks has been the request for further wonders—a business-like view of our *raison d'être*, and of the value as an insurance of any support given to the profession, which only calls for the comment that the increased labours in prevention which are demanded must further victimise us. President Eliot eloquently urges all medical schools "to supply the twentieth century physician who shall prevent the access of epidemics, limit them when they arrive, defend society against bad food and drink, and reduce to their lowest term the manifold evils which result from the congestion of population." But these utilitarian claims will extend far beyond the safeguards against mortal disease and economic losses incidental to sickness. There are other needs, less familiar to lay thinkers, and consciously reasoned out only by a minority of the profession, but voiced by the logic of facts. In addition to "the teaching" and "the study" of prevention, guidance will be needed in wider fields for the cultivation of health. The State looks to us for the supply of a vigorous as well as sound race of workers and warriors. But there remains another great department, that of the mind. We are still struggling with the elementary stage of the cure of mental disease; and the study of its prevention is hardly begun. But the cultivation of mental health, with all its physical, intellectual, moral, social and political consequences, is a vast duty for our future occupation. Who else can undertake it?

The unhallowed perpetuation of sinister heredities, and other elementary failures in eugenics, call for a remedy. Wider still is the task of strengthening mental and moral health in the growing generation by a judicious interaction of the physical and of the mental factors; and of encouraging among adults that physiological rectitude without which there can be neither longevity for the individual nor increase for the race. In all these directions there is ample scope for the study, the teaching, and the individual service of the profession, but for the success of its ministrations it will need the support of the State.

The future earning power of the profession is not easy to estimate, but we may infer that as emoluments for private services decrease, there will be a slight tendency towards an increase in remunerated public work.

We have seen our busiest days in the treatment of Disease, henceforth our livelihood must be increasingly derived from the Care and Culture of Health. The greater part of that remuneration must ultimately be derived from the State. The long delayed medical inspection at schools is a first instalment in that direction; but much larger work should follow, which would employ larger numbers. The registration of each individual health, with a view to prevention, is not a Utopian view, but a measure suggested by common sense. Each growing leaf in tobacco plantations is registered and watched. Our own Excise appoints a special officer to watch the still. We shall not succeed in stamping out tuberculosis until a health watch is kept over each life, that by timely treatment it may be made germ proof. The highest skill is essential for this class of work, and will call for adequate remuneration. Personal certificates of health could be paid for by the smallest number of taxpayers. For the majority, any difference unpaid by the individual would be charged to the public funds. What applies to certificates would *a fortiori* apply to the attendance on actual disease, which could no longer be charged as a private tax on the practitioner.

CONCLUSIONS.

This imperfect sketch can only suggest outlines, not any of the details:—

(1) As a profession we can advise and we can act: but the business of health is of the State. *State organisation and subvention* for increasing labours undertaken in its service are unavoidable, even at the cost of public treasure, and for us of a nominal loss of independence.

(2) *A ministry of public health and a State examination* are the definite steps for immediate contemplation.

(3) Our practical policy is to be "prepared for any fate" by an *unlimited adaptability* for the coming changes, of which we only know that they will exceed the record of the past. And this means raising the preliminary educational standard to its highest pitch, which can never be too high for the possibilities ahead. This is also our only plank of safety from the dangers of over-crowding and of disorganisation.

(4) Indispensable to teachers and to rulers, our co-operation should be worthy to command its own terms.

(5) The fundamental reform in the status and remuneration of the profession demanded by its vast labours and service can only be won by high standards of self-improvement, and by the combined efforts of the highest and most influential with the rank and file.

(6) The details of reorganisation are beyond the wit of individual man, but would evolve from the operation of the four principles which are essential:—(1) Exclusion from our portals of any but the highest preliminary educations; (2) uniformity of the professional State qualification; (3) recognition of the equality in claim to adequate remuneration; and (4) assumption by the State of those responsibilities which are not ours but of the State.

Our future wage should not fall sort of that competency which allows scope for the best work. Wealth it never will be. As of old it must remain largely a consciousness of doing our best as healers and helpers, as students and teachers, and as a moral and intellectual *élite*; with the added satisfaction of belonging to a profession not only honourable but honoured.

DR. PETER FRASER, medical officer of health for the Carnarvonshire Joint Sanitary Authority, is surrendering his post in order to take up the position of a medical missionary in India.

THE GOVERNMENT'S SCHEME TO PROMOTE THE UNQUALIFIED PRACTICE OF MEDICINE.

By J. C. McWALTER, M.A., D.P.H., M.D.Brux., F.F.P. and S.Glas.

Of the King's Inn, Barrister-at-Law.

LET us clear our minds from cant. What is the genesis of this Notification of Births Bill? and what must be its effects—on the population and on the practitioner?

To start with, we must remember that it is not merely futile to discuss the matter even now, for, although the Bill has passed, the Act is an adoptive one, and if strong objection can be shown to its effects, it simply will not meet with any large measure of acceptance by local authorities.

Huddersfield is a very progressive town, with a population under 100,000. It was blessed with a most intelligent and philanthropic mayor, Mr. Broadbent, and a most active and forceful Medical Officer of Health, Dr. Moore. They devised a plan whereby prizes were offered to mothers who kept their offspring alive to a certain age, and who notified the authorities immediately of the occurrence of a birth. On this notification nurses were sent to instruct the mothers in the care of the infants, &c. Apparently, as a result of these efforts, the infantile death-rate in Huddersfield went down greatly—although in 1906 it seems to have been only about 7 per cent. below the average, and Mayor Broadbent and Dr. Moore naturally rejoiced, and proclaimed in every congress and from every hill-top their success. So thoroughly did they succeed in influencing the public mind to believe that they had discovered an important weapon in dealing with infant mortality, that a Bill has been brought in and passed by the Government requiring doctors, under pain of a penalty, to give early notification of births.

I happen to have got myself into considerable trouble by questioning the wisdom of the Huddersfield scheme, but I am still unconverted, and do not think it wise that ill-digested legislation, based, practically, on a few ill-considered instances, should be thrust on the whole country. I contend that the effect of the Notification of Births Bill is to open wide the door for the unqualified practice of an important department of medicine by midwives or by persons of still less skill.

If Huddersfield is to be set before us as the Great Example of municipal righteousness in the production of a healthy population, and if laws, based on its example, are to be thrust down our throats, it cannot complain if we examine its claims to excellence more closely.

Obviously, it is idle to consider the death-rate of a small section of the population. You must look on the whole to gain any idea of the facts. The last statistics of Huddersfield show, I believe, a birth-rate of 22, and a death-rate of 19. It is a fundamental principle of vital statistics that an infantile death-rate is only an indication of importance as to the health of a locality when it is compared with the infantile birth-rate. Now, 19 is rather a small death-rate; it seems to compare very favourably with Dublin, where it is 25. But the Dublin birth-rate is 33, and hence the population of Dublin continues to increase two and a half times as quickly as that of Huddersfield. That is, under Dublin conditions—such as they are—the number of persons who survive to the service of the State is two and a half times as great as in Huddersfield.

These questions can only be studied profitably when we examine millions of examples. We have them in France. Practically every point of importance in the Huddersfield system is copied from French methods—but the population of France was forty millions thirty years ago, and is practically the same to-day.

I submit, therefore, that Huddersfield is a very bad, in fact, a fatal, model by which to regulate the families of the nation. Of course, I know that Mayor Broadbent and Dr. Moore would both insist that they were only anxious to check an apparent wastage in infant life, and had not the slightest desire to see the number of births checked. But I would point out, whilst giving them ample credit and praise for their endeavours, that we are bound to examine the facts as they work out—with all their attendant circumstances. If, therefore, we find that the difference between the actual birth-rate and total death-rate in Huddersfield is so small that it would mean ruin to the nation if the same figures prevailed in every other town, I submit that Huddersfield is not an example to be followed, or to be made the groundwork for general legislation.

I am open to conviction and correction on this point, but I believe that in every place—or certainly in the vast majority of places—where there is a low infantile death-rate, there is also a low infantile birth-rate. The question for us, as scientific men, to decide is, whether it is *post hoc* or *propter hoc*. The question is not only of the greatest importance to the British Empire, but also to the whole white race. If all white peoples continued to increase in numbers only at the Huddersfield rate, in thirty years' time the Japanese, with their high birth-rate, would overrun the world. Moreover, it is abundantly proved that where the infantile death-rate is kept small, a vastly larger proportion die in the third, fourth, fifth, and sixth years of life, and a vastly larger proportion of the survivors are afflicted with some bodily or mental defect and become burdens to society.

But what is the early notification of births for? It is to send an unqualified person to occupy the place of the doctor in superintending the care of the mother and child. She directs all that pertains to the hygiene of the child—its food, clothing, air-space, time of outing, and every detail of its life. Now, the sanitary inspector charged with these duties—this illegal medical practice—may, in a sense, never have seen a child before; she need never have been in a hospital, or seen a case of contagious disease; she simply holds the certificate of a sanitary inspector. Nothing is more certain than that the major part of her work will be to diagnose infantile ailments, and to prescribe for measles, scarlet fever, gastric or bronchial troubles, meningitis, &c. Of course, she will be ordered to do no such thing by the sanitary authorities, but from the nature of her avocations she will be consulted constantly about these things. The effect, therefore, of the Notification of Births Act, where adopted, will be to create a trade of unqualified practitioners. I happened to glance at the proceedings of the General Medical Council for 1898, and I find a practitioner, of unblemished reputation, haled before the Council to answer a charge—of what?—that, having a case of confinement under his care, he sent a woman to attend it during the interval between two visits! And we, at the public charge, propose to send out ignorant women to attend mothers and their babes, and to give instruction as to their care, where no doctor may see the child first or last.

The essential object, then, of the Notification of Births Act, is to send an unqualified person to direct the care of an infant, and at the public cost; though if a practitioner should do the same thing with his private patients, and with the most skilful nurse under his own observation, he would be struck off the register for it.

A WORD FOR TRYPSIN.

By A. K. MATTHEWS, M.R.C.S., L.R.C.P.

The utter powerlessness of medicine or surgery to relieve patients is frequently experienced by medical men, but never more poignantly than in the last stages of cancer. One therefore welcomes any success in this almost hopeless warfare, and it is with much pleasure I quote my experience of trypsin in a case of inoperable cancer of the tongue.

Briefly, the notes of the case are the following:—T.H., a boatman, æt. 58, no family history of cancer, no history of syphilis, and urine normal. When I first saw him he was suffering from large fungoid ulceration of the left side of the tongue, which had been slowly extending for seven or eight months. The tongue on the side of the growth was fixed, causing difficulty in speech and deglutition, and he was unable to take solid food. The salivation was excessive, and the hæmorrhage on three occasions severe, the loss each time being three or four pints. The submaxillary and cervical glands were greatly enlarged, causing stiff neck, and the pain in the growth and the glands was at times very severe.

There can be no doubt about the diagnosis, as he had been sent to Guy's Hospital, where he was advised that the case was too far gone for operation. Considering the extent of the disease, it was almost without hope that I recommended the trypsin treatment, and before commencing the injections I told T.H. they might give him considerable pain and not much benefit. He, however, welcomed any chance of relief, and I began the hypodermic injections of inj. tryp. co. (Allen and Hanbury), and liq. tryp. co. by the mouth.

Without exaggeration, I can describe the result as marvellous. After three daily injections (15 min.) he expressed himself as feeling "twice the man," his tongue was freer, and I could understand all he said. After a week's daily injections I increased the dose to 30 min., using it every other day with liq. tryp. co. t.d.s. He continued to improve rapidly. The glands entirely disappeared, the growth was reduced to half its size, no further pain, salivation greatly reduced, no recurrence of hæmorrhage, and speech and deglutition markedly improved. The effect constitutionally may be summed up in the man's own words: "I feel a different man altogether," and he began to look forward hopefully to tackle his work again.

I continued the treatment for a little over two months, always injecting the left buttock or flank. He experienced no pain, nor was there ever any sign of inflammation—in fact, nothing but the best results.

I left the case in the hands of another medical man (I was at the time doing *locum* whilst the practice was passing from one medical man to another), and I regret that my successor "had no faith in trypsin." The treatment was discontinued, and the man died six months afterwards.

Dr. H. writes to me that he saw no indication to continue trypsin, as there was "no pain or hæmorrhage," and death was due to exhaustion. Dr. H., however, includes a very important statement in his letter, in which he says: "I have now a case of pyloric cancer, and am going to give trypsin a good trial." *Verb. sap.*

The first meeting of the Obstetrical and Gynæcological Section of the Royal Society of Medicine will be held on October 10th at 7.45 p.m. Professor W. E. Dixon and Dr. F. E. Taylor will read a paper on "The Physiological Action of the Placenta."

THE OUT-PATIENTS' ROOM.

CHILDREN'S HOSPITAL, PADDINGTON GREEN.

Habitual Dislocation of the Thumb.

By Arthur Edmunds, M.S., F.R.C.S.

Among the patients was a boy, æt. six, who had fallen down when a year and eight months old, and dislocated the terminal phalanx of the right thumb. Ever since the accident the thumb had been continually liable to a repetition of the dislocation, although at the time it was reduced in the usual way and efficient suitable after-treatment adopted. On examination one found that the terminal phalanx was acutely flexed upon the next bone with a marked rotation, so that its palmar surface looked almost directly backwards. There was very considerable impairment of the usefulness of the hand as the thumb was kept flexed into the palm. The dislocation could be reduced quite readily, and indeed the boy was able to do this for himself, but after reduction the slightest attempt at flexion of the joint reproduced the deformity. A skiagram was taken which showed that the end of the proximal phalanx was smaller and more pointed than normal, and it seemed reasonable to assume that this was the cause of the recurring deformity. In view of the extreme disability it was necessary to perform some operation which would render the joint more stable, or at least so stiffen the junction between the two bones that the thumb could be used. Habitual dislocations are by no means uncommon, and they are usually due to disproportion in the articulating surfaces of the bones which form the joint; as a secondary result of this, the ligaments which form the joint's capsule are often extremely lax. The strength of a joint depends upon two factors, in the hip joint, for example, the articulating surfaces are extensive and accurately fitting, so that dislocation is prevented even if the capsule were a little lax, in other cases, for example, the knee joint, although the articular surfaces are not very accurately opposed to each other, yet the ligaments and muscular structures which surround the joint combine to form one of the firmest articulations in the body. In the present case the deformity was, as Mr. Edmunds pointed out, due to the deformed condition of the proximal phalanx, which was pulled out of position by the tendons of the long flexor which are inserted into the base of the terminal phalanx. In order to rectify the condition it was obvious that the pointed end of the proximal phalanx must be removed with a liberal amount of the shaft of the bone so as to give an increased surface to articulate with the terminal phalanx. Fortunately so far as muscular insertions are concerned this piece of bone is unimportant, and the bone increases in length almost entirely from the other end. An incision of about an inch was made along the inner border of the thumb, the structures around the head of the bone separated from it until the last half inch was satisfactorily exposed, this was then removed with cutting forceps, and the wound sutured and dressed. As regards the ultimate success of the operation, Mr. Edmunds remarked, it is, of course, impossible to say, but there was no tendency for the terminal phalanx to fall into its previous faulty position, and there was no tendency to flexion of the thumb into the palm of the hand, so that it is probable that after the stiffness which is fairly certain to follow has worn off an excellent result will be ultimately obtained.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Pirogoff's Amputation.—Mr. Willmott Evans operated on a man, æt. about 60, who had been admitted for gangrene of the foot. About a month before, after a slight injury, several of the toes had become black with complete loss of sensation. After a longer or shorter time the toes had sloughed away, leaving exposed the four outer metatarsal bones, while of the great toe a portion of the proximal phalanx still remained. No extension of gangrene occurred, though the patient was kept under observation for several days. His general health seemed good; the arteries were not much hardened. Pulsation could be felt in the popliteal and slightly in the anterior tibial at the bend of the ankle. Some slight pulsation was palpable in the posterior tibial behind the internal malleolus. It was decided to remove the foot. The exposed bones were carefully covered with a dressing so as to lessen the chances of infecting the operation wound. The skin around the ankle having been cleansed, Mr. Evans entered a Syme's amputation knife at the tip of the external malleolus and carried it downwards and forwards at an angle of about 60° to the sole of the foot; it was then carried straight across the sole and then upwards and backwards to a point on the inner side about three-quarters of an inch below and behind the tip of the internal malleolus; this incision was deepened down to the bone. A straight cut was then made across the front of the ankle joining the extremities of the original incision. This was deepened, all structures being cut through until, the anterior ligament of the ankle being divided, the joint was opened. During this incision the anterior tibial vessels were divided, they were seized with Spencer Wells' forceps, though they bled but slightly. The bleeding also from the plantar incision was but slight and easily controlled. With the point of the knife the lateral ligaments of the ankle joint were divided. The foot was fully extended, and the posterior ligament was cut through and the tendo Achillis exposed. A saw was then introduced behind the astragalus and the os calcis was sawn downwards and forwards in the plane of the original incision and the foot removed. The skin and structures around the malleoli were carefully turned upwards for about an inch and a half; the tibia and fibula were then sawn from before backwards and slightly upwards, the plane of section forming an angle of about twenty degrees with the horizontal, the whole of the articular surface of the joint being removed. All discoverable blood vessels were tied whether bleeding or not, and the remains of the os calcis with the heel flap turned up so as to meet the sawn surfaces of the tibia and fibula. A silk stitch was then introduced uniting the periosteum of the tibia to the periosteum of the calcaneum. Skin sutures were put in, no drainage being employed. A light dressing of sterilised gauze was put on and very loosely bandaged. The patient was put back to bed with the leg lying on a pillow and gently held in place by sandbags, no splint being employed. Mr. Evans said this case was one of senile gangrene, and even at the present time there is considerable divergence of opinion as to the best treatment to be followed; in his own opinion the treatment may have to vary very much according to the individual case. The chief difference in treatment is as to the site of amputation; some surgeons are in favour of amputation limited to the affected part, while others urge that if amputation be done low down in these cases recurrence of gangrene is almost certain because of the thrombosed condition of the anterior and posterior tibial arteries. Therefore, they advise an amputation high up, say, the lower third of the thigh, as much more likely to be followed by recovery. There is certainly in these cases, Mr. Evans pointed out, a very great tendency to recurrence of gangrene after amputation, but the thrombosis of the vessels is not the only factor in the production of this gangrene; sepsis is almost equally important, and if sepsis can be avoided the risk of the recurrence of gangrene is much diminished. The chief points in determining the site of amputation to be adopted in senile gangrene are, he considered, the following:—

(1) The state of the vessels: if all the arteries supplying the foot are completely thrombosed the chance of a satisfactory result of an amputation low down is small, but if even one of the tibial arteries can be felt pulsating that in itself is in favour of the lower operation; (2) the character of the progress of the gangrene: if it stops completely and shows no tendency to reappear higher up, the less the risk of the lower operation, but if it is spreading, however slowly, there is always a large element of risk in any amputation low down. In this patient there was no evidence of any immediate extension of the gangrene, and there was definite pulsation in, at least, one of the tibial arteries; therefore he thought it justifiable to limit himself to amputation of the foot. When that decision was arrived at the question arose as to what amputation should be done: from the extent of the tissues already destroyed it was obvious that only two alternatives were possible: Syme's amputation or Pirogoff's. In deciding between these two operations we had, he said, to take into account the reason of the amputation, the condition of the patient, and the nature of the stump produced. For cases of disease of the bones of the foot such as tuberculosis there could be no doubt that Syme's operation was preferable, but when the cause is traumatic or strictly limited to the anterior part of the foot Pirogoff's method is the better. As to the condition of the patient the heel flap in the Pirogoff is much less likely to slough than the heel flap in the Syme, for the latter flap cannot but be more damaged in being formed. In a case like the present where the vitality of the heel flap was gravely compromised by the condition of the arteries the small amount of disturbance of the tissues in the Pirogoff operation was a decided gain. The value of the stump produced depended, in his opinion, greatly on the manner in which the operation was performed; when, as in Pirogoff's original operation, the os calcis is sawn vertically and the tibia and fibula are sawn horizontally, the treading part of the stump is formed by the soft skin just behind the ankle since the heel flap has to be rotated through 90°; such a stump is not well adapted for walking; this objection can be entirely done away with if the os calcis is sawn downwards and forwards and the leg bones backwards and upwards, for the rotation required of the heel flap is then only about 20° or 30°. A well-made Pirogoff stump is admirably adapted for bearing pressure, and he had known of a case of a double Pirogoff in which the patient could run freely on his bare stumps. It would have been noticed, he pointed out, that no tourniquet was employed. This was done intentionally, for he felt sure that a tourniquet favoured thrombosis and so prejudiced the vitality of the stump; and in these cases no tourniquet was needed, for the hæmorrhage was always easily controlled It had been seen in this case how very little blood was lost. Another point of importance was, he considered, the advisability of bandaging the stump as lightly as possible; just sufficient dressing was employed and a few turns of a bandage to hold it in position. It was hardly necessary to point out the intense importance of asepsis in dealing with tissues whose vitality was already greatly lowered. One other matter he might mention; it is always advisable to stitch the piece of os calcis to the tibia, either with silk or wire. In the present case he was content to stitch the periosteum as less likely to do harm.

The further progress of the case was satisfactory. Except for a little moisture at one portion of the skin wound the healing was by first intention; the skin stitches were removed at the end of a week; the wound was soundly healed in three weeks from the date of operation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 29th, 1907.

Drainage in Gynæcology.

The history of drainage of the abdominal cavity does not go beyond 1850, says Prof. Pozzi.

Peasley, in 1855, was the first to have recourse to drainage of the abdominal cavity in every case where he feared the exudation of a liquid (pus, blood, etc.) into the abdomen, by placing in the vagina an elastic catheter, which penetrated in to the cul de sac of Douglas.

In 1867 Kœberlé recommended the drainage of the abdomen directly through the wound by means of a glass perforated wound; this practice was adopted with slight modifications by Spencer Wells, Keilt, etc.

Later, in 1872, the eminent gynæcologist, Sims, proposed draining systematically all cases of laparotomy, on the grounds that the death of every patient after the operation of laparotomy was due to septicæmia and that exudation was found in the abdomen at the autopsy.

The ideas of Sims were adopted by Nussbaum (1874) and Olshausen (1876).

In order to have a correct idea of the utility of drainage, it is necessary to understand the function of the peritoneum, in normal and pathological conditions.

In the healthy state, the peritoneum absorbs easily liquids of slight density (water, semen, blood).

Wagner demonstrated in 1876 that the serous membrane could absorb from two to six quarts of salt liquid in the twenty-four hours, and that a relatively large quantity of infectious substances could be eliminated by the peritoneum or encapsulated by means of exudations, without danger to the patient. But for this the membrane must be intact.

In every case, on the other hand, where the peritoneum is infiltrated and poisoned, its physiological properties are destroyed. It ceases consequently to be absorbent when it is macerated by ascites coexisting with a tumour, its epithelium being thus destroyed.

Drainage is indicated when there is positive or imminent infection of the seat of operation, and to ensure the evacuation of the liquids, and above all to avoid possible accumulation of blood.

In operations for salpingitis, some of the pus might fall into the seat of operation. If it were aseptic no harm would be done, but generally the wound is infected. By closing completely the incision, the microbes contained in the pus would produce peritonitis. If, on the contrary, drainage was practised, the infection is limited and the liquids secreted by the peritoneum against the microbes are evacuated at the same time as the microbes.

Drainage allows also sequestration of the infected spot, for around the drain plastic peritonitis develops; an artificial membranous canal is formed, protecting the neighbouring parts.

Each time, in laparotomy, the presence of a liquid, ascites or other, drainage must be practised and continued three or four days.

When an effusion of blood is produced, the drain should be used not only to evacuate the clots which would be absorbed with difficulty but also to produce hæmostasis, for, when capillary hæmorrhage meets with the rough surface of a drain or plug, it coagulates and the drain becomes thus an hæmostatic centre.

In great oozing of blood as in the decortication of a large tumour a drainage practised according to the method of Mikulicz becomes an agent of compression.

The drainage can also be done per vaginam, and many foreign surgeons give it the preference. In France, Richelot believes vaginal drainage superior to abdominal drainage.

M. Pozzi drains through the vagina only when it is completely opened at the end, that is to say, after vaginal hysterectomy.

Hegard drained by means of an enormous indiarubber tube, fenestrated, into which he introduced antiseptic plugs which were changed when they were completely infiltrated.

At present, in France, drainage is done by elastic tubes (tube of Chassaignac), supple but resisting, they are always fenestrated.

Another method, abandoned for a long time, after enjoying great favour, consists in the use of plugs.

It was Kehrer, in 1882, who brought this method back to public favour. Bands of aseptic or antiseptic gauze replaced the cotton hitherto in use. These plugs act like a drain; but thanks to their capillarity, they aspire all liquids and are consequently superior to the indiarubber tube, at least in the first few days following the operation.

In 1884 Mikulicz published an important pamphlet in which he recommended the method employed to-day by a large number of surgeons.

His method is not only a drainage of the abdomen, but also a plugging of a portion of the abdominal cavity.

Where there is a large denuded surface to be drained, two, three, or four plugs have to be placed together. When at the end of a certain time it becomes necessary to remove these plugs they are all stuck together, and to the edges of the wound; to withdraw them, a considerable effort is necessary and suffering is caused to the patient.

Mikulicz conceived the idea of placing these plugs in a bag. The bag, empty, is placed in the centre of the incision and pushed gently to the bottom of the wound. To this bag is fixed a long and strong silk cord of which the end is fastened outside on the wall of the abdomen by an adhesive plaster; the bag is filled with the plugs and then closed. At the end of a few days the plugs are withdrawn quite easily, one after the other, and finally the bag is removed by drawing on the silk thread, without causing the slightest suffering to the patient.

CORYZA IN INFANTS.

Coryza in infants is, as all know, a very troublesome affection, preventing the development of the child. Two or three drops of glycerine three or four times a day bring about a speedy cure.

MUSHROOM POISONING.

A few tablespoonsful of powdered charcoal or animal black in milk or water are sufficient to arrest the most acute symptoms.

GERMANY.

Berlin, Sept. 29th, 1907.

AT the Medizinische Gesellschaft Hr. Goldscheider communicated a note on

PERCUSSION OF THE LUNGS.

He first described the method in general use, and drew attention to the methods of Ziemssen, Gerhardt, and Krönig, and observed that they were capable of improvement, as they were not based on exact pathological knowledge of the anatomical relations of the apex of the lungs. These relations the speaker showed by drawings, and came to the conclusion that the apex was best percussed between the two heads of the sterno-cleido-mastoid. In percussing the apex of the lung from the back he did not percuss over the supraspinous fossa, as there was no lung tissue there, but recommended percussion over the two first ribs after the attitude proper for the examination had been assumed (sitting with the arms slung round a chair back). By this the shoulders were drawn widely apart on both sides, and the ribs exposed. Percussion performed in this way was of more value than auscultation. It should be performed lightly.

Herr Ewald did not think much of the importance of percussion based on anatomical position; it was a matter of the projection of the sounds of the lung into the neck, rather than of determining changes. The previous speaker had not mentioned a good kind of physical examination of the apices of the lungs, namely, direct clavicular percussion. He was in the habit of using a method that seemed useful to him, namely, percussion of the apex from behind.

Hr. Westenhoeffer observed that, with percussion between the heads of the sterno-cleido-mastoid, glands in that position might easily be percussed that might be enlarged in incipient tuberculosis.

At the Verein für innere Medizin Hr. Westenhoeffer demonstrated the organs from a case of

PLETHORA VERA.

A telegraph worker was admitted into the Moabit Hospital with symptoms of meningitis, and died in ten days. In the fluid obtained by lumbar puncture, and which flowed out under great pressure, leucocytes were found, and on puncture a second time lymphocytes. The autopsy revealed as the direct cause of death meningeal hæmorrhage into the left lateral ventricle; but besides this quite peculiar features were observed. All the organs were overfilled with blood (heart, liver spleen, kidneys, stomach, pancreas, and bones). The organs preserved in formol still showed a dark blue-red colouration. The case was one of plethora vera. The etiology of the affection was completely dark. The watery constituent of the blood-serum was not diminished, as shown by Weintraub, but somewhat increased; there was no thickening of the blood therefore. The disease in the bone marrow was characteristic; this was dark red, and it looked just as it did in little children, in a state of infantilism. The patient did not suffer from cyanosis, but the face was very red. He had never had any signs of circulatory disturbance, and had been of a quiet temperament. The spleen was not greatly enlarged, and its tissue showed no changes. The blood did not differ from the normal, and in particular it contained no nucleated red blood corpuscles. The heart was not enlarged, and showed no deviations from the normal. It was the same with the aorta. The kidneys were slightly enlarged, but not changed. The lungs were over-filled with blood. Only five cases had been published.

Hr. Hirschfeld remarked on the case that the lymph glands were normal. The spleen showed diminution of the follicles, with hyperplasia of the pulp; normoblasts and myelocytes were present in the blood of the spleen. The bone marrow was red through engorgement; the quantity of normoblasts was not greatly increased. Hyperplasia of leucocytes. The chief feature was the change in the bone marrow.

Hr. Max Michaelis was of opinion that not five but many cases of plethora vera had been published, but only five with autopsies. Possibly the disease had some connection with impeded respiration.

Hr. Mohr had seen eight cases in three months. The patients were not cyanotic but flushed; there was no swelling of either spleen or liver. In three the patients had had to do with carbon monoxide. The number of red blood corpuscles in his cases oscillated between seven and eleven millions.

Hr. Westenhoeffer observed that the discussion showed the confusion that reigned as regarded the views on the subject. The cases related by the speakers did not belong to the category of those reported. In those there was absolutely nothing of impeded respiration, of carbon monoxide poisoning, or of concomitant disease. The sole cause of the plethora was the change in the bone marrow. They were cases of myeloplastic polycythemia, the true plethora vera of the older authors.

AUSTRIA.

Vienna, Sept. 29th, 1907.

DIAGNOSIS OF CEREBRO-SPINAL MENINGITIS.

THE differential diagnosis of sporadic "stiff neck" has been puzzling the profession for some time, and every experiment and expedient has been resorted to with the real object of solving the problem. Hölker records 15 cases of this disease, and only six of them responded to the bacterial test during the first week of the illness. In other two cases of the 15 the test was positive after one week's duration of the disease. The remaining seven never responded to any test, although the spinal fluid was examined long after as well as during the illness.

Recently a new theory for the differential diagnosis has been supposed to be established in the state of the lymphocytes in the liquor cerebro-spinalis.

Hölker thinks this rather speculative, and ought to be entertained with caution.

The syphilitic or para-syphilitic and tubercle are the two closely allied diseases which require to be eliminated from the cerebro-spinal meningitis. He finds the same leucocytes in simple meningitis and undoubted tubercle as in cerebro-spinal meningitis, and affirms that the latter has a great number of forms among the white blood corpuscles.

He concludes that the specific coccus is too late in its appearance for any practical use that can be made with it, even when it is found.

The Chronicity of Icterus is Hæmatic.

Benjamin and Sluka, after long and careful examination of icterus, have come to the conclusion that the disease is hæmatic and transmissible from father to son. In several cases which they have observed, no physical or anatomical difference could be found in the organs of the body, but they have found the disease ameliorated or attenuated in the third generation when the grandfather, father, and son were examined; the latter had the disease in a less intense degree than the grandfather.

In the child the icterus was decidely less, the urobilin and urobilinogen diminished, the hæmatoporphyrin and cholic stools were entirely absent. The hæmatic changes are the most notable; the red blood corpuscles are fewer, but the individual erythrocyte holding a surplus of hæmoglobin or poikilocytosis produces a blood anomaly, which leads them to believe that the production of the blood or some noxa is the disturbing factor in the production of icterus. The first exciting cause seems to be the destruction of the erythrocyte, while the increase of the spleen in father and son acts as a "spodogener" in accomplishing the destruction of the red blood corpuscles.

Balantidium Coli Typus Malmsten.

Glaessner showed microscopic preparations of a living parasite taken from the stools of a patient suffering from amœban enteritis. The protozoon was very mobile, and could be easily distinguished as the balantidium coli, measuring 0.01 by 0.07 millimetres and having an oval appearance. The body is covered with a fine hair which assists it in its boring and oscillating motions when moving forward. It is usually transmitted to man through the dejections of pigs, and carried to the intestine of the human being by green tubers and vegetables. The usual therapeutics are small doses of calomel from 0.05 to 0.1 of a gramme, with quinine, extractum filicis maris, carbolic acid in pill and ice water clysters. The latter is the more effective, but it has to be used boldly with the other adjuncts.

Obituary.

Another of Austria's medical philanthropists has passed away in the person of Dr. Anton Loew. An alumnus of Vienna University he studied under Oppolzer, graduated and, according to the custom of the day, travelled over Europe. On his return he built and equipped a hospital in 1881 with the latest improvements of the time, which gave an impetus to the progress of medical science in Austria. He was associated with Billroth in founding the Red Cross, and was consulted in the erection of all hospitals in the Empire.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Resignation of Dr. Rutherford, Crichton Royal Asylum.—It is announced that Dr. Rutherford has resigned the post of Superintendent of the Crichton Royal Institution, Dumfries, which he has now occupied for nearly a quarter of a century. General regret will be felt that reasons of health have compelled him to take this step. Since he received the appointment he is now about to demit, the Crichton Asylum has been greatly enlarged, thanks to his unremitting energy. The pauper patients have been removed from the neighbourhood of the institution, and placed in a separate asylum in the grounds, which extend to 800 acres. A handsome memorial church has also been erected, and the country house of Friar's Carse, formerly the property of Mr. Crichton, the founder of the institution, has been purchased. All these improvements have been carried out at the instigation of Dr. Rutherford, and their magnitude may be judged of when it is stated that together they cost over £110,000. Dr. Rutherford was born in 1840, and after studying his profession in Edinburgh and on the Continent, he returned to Scotland in 1866 with the intention of entering upon general practice. He translated Griesenger's "Mental Diseases" for the new Sydenham Society, and this evidence of the direction in which his tastes lay led to his being offered an assistantship in the Birmingham Asylum. In 1870 he succeeded the late Sir John Sibbald as Superintendent of Argyll and Bute Asylum, and thence was translated to the large asylum of Lenzie. It was in that capacity that his introduction of recent methods of treatment—extension of employment and freedom for the patients—won for him general recognition as an asylum administrator. His work attracted much attention all over the world, and he received the honorary membership of a number of foreign Psychological Societies—French, Belgian, Italian, and American.

Problem of the Inebriates.—The Corporation of Glasgow have issued their sixth annual report on the working of the Girgenti Inebriate Reformatory, which is licensed for females only, and has accommodation for 58 inmates. The report covers the year 1906, and has been delayed in consequence of an abortive attempt by the Corporation to have the Inebriates Act amended. In consequence of their failure to do this and also on account of a reduction of the Treasury grant from 10s. to 7s. 6d. per inmate per week, they have resolved to discontinue this reformatory. On December 31st, 1905, there were 41 inmates, and during 1906 there were 17 fresh admissions, the total number since the opening of the home being 130 patients. The average age of the 1906 admissions was 27 years. The inmates are employed at farm work, sewing, knitting, etc.; a number of them, accompanied by attendants, are permitted to visit their friends for a day. Writing and receiving letters is permitted. Gratuities of 3d. a week for good behaviour, and 3d. a week for work done, are allowed. Concerts and musical evenings are got up, and educational facilities are afforded in the evenings. Nine patients were allowed out on license under the charge of suitable guardians. Of these, three relapsed and were re-admitted; two did well, but were re-admitted for accidental reasons; two did well, and their sentences expired while under license; two are at present doing well. A large number of escapes took place, which is no doubt partly due to the fact that the institution is not walled in. Twenty-four inmates were involved in attempts to escape; two are still at large. The expenditure amounted to 24s. per inmate per week, of which 10s. 7d. was provided by the Treasury, and the balance by the Corporation. Dr. Cunningham, Medical Officer, states in his report that three inmates are, in his opinion, border-line cases, and may require to be transferred to an asylum. Four inmates have required treatment for epilepsy. Dr. Cunningham adopts the following classification of the patients:—(*a*) 1st class, excitable hysterical patients with inability to control temper and passions; (*b*) 2nd class, weak-minded, imbecile patients, who are indifferent to their surroundings, and make no attempt to conceal their position; (*c*) 3rd class, accidental or periodical drunkards, in whom a fit of depression precedes a bout; they have small resisting power, and are easily led for good or bad; (*d*) 4th class, patients in poor physical condition and mental health, from unhealthy surroundings, bad food, neglected education; the drinking bout is of long duration. Of the 130 patients admitted since the home was opened, the distribution among the different classes was as follows:—(*a*) Hysterical patients, 18; (*b*) weak-minded, 17; (*c*) accidental drunkards, 22; (*d*) chronic inebriates, 73. Dr. Cunningham regards the chronic inebriates as practically hopeless. The treatment is essentially the same as that of mental disorders, the object being not merely to stop drinking, but to suppress the craving.

Two years ago drug treatment was begun, the remedies used being atropin. sulph. gr. 1-100 daily, and a mixture containing sodium, quinine, ammonium, and aloin. It has proved an absolute failure. Turning to the tables of discharges for 1904, 1905, and 1906, we find the after histories of 54 patients. Of the 29 who were discharged during 1904, all except seven had further convictions against them during 1905 and 1906, and therefore must be regarded as failures. Of the seven who escaped conviction one married and has relapsed, one is unknown, one is dead, one is in the poorhouse, one did well while on license, two continue to do well. Of the 22 who had further convictions against them, one is said to be in domestic service and doing well, another did well but is dead, and another is a farm servant. That is to say, two out of 29 remained cured for at least two years, and two more did fairly well. Of 16 patients discharged during 1905, seven escaped further conviction, three are known to have relapsed, one is in Canada, and three are doing well. Only one of those convicted for drink is known to be doing well now. Of the nine patients discharged during 1906 only three are known to be doing well. Excluding the last year, we thus have total discharges of 45; of these five are cures at the end of 18 months to 2½ years; four have had subsequent convictions, but are doing well now. These figures need no comment; they tell plainly enough how little prospect there is of reforming the class of patient who is admitted to an inebriate home. It is hardly to be wondered at that the Corporation of Glasgow have resolved to discontinue the Girgenti Retreat.

EDINBURGH POST-GRADUATE COURSE.—This course was brought to a termination on September 27th, and has proved even more successful than its predecessor of last year. On September 13th the President and Fellows of the Royal College of Surgeons gave an "At Home" to members of the course, and the post-graduates, in their turn, showed their appreciation of the classes by entertaining their teachers to dinner at the Caledonian Station Hotel on the 26th.

BELFAST.

THE LATE DR. MULLAN, OF BALLYMENA.—Dr. Andrew Mullan, of Ballymena, co. Antrim, who died last week at Larne, was well known for many years in his county. He graduated in the old Queen's University in 1866, taking the degrees of M.A. and M.D. He took a widespread interest in various religious and philanthropic organisations, and will be much missed in his district, where he was highly respected.

PUBLIC HEALTH.—The Public Health Committee of the Corporation is following up its campaign of bill-sticking by issuing a card of instructions as to precautions to be taken against tuberculosis, and proposes to send this card to schools and factories.

HOUSE REFUSE.—The question of ashbins instead of ashpits was discussed at the last meeting of the Committee, and it was stated that the annual cost of the fortnightly cleansing of 80,000 ashpits was estimated at £31,000, while the removal of the contents of a similar number of ashbins would be less than £20,000. The bin system has been in use in Liverpool for many years, apparently giving satisfaction, and it is probable that it will be introduced into Belfast.

The number of cases of cerebro-spinal meningitis notified last week was only four, and one death occurred. The total death rate from zymotic diseases was 1.8.

LETTERS TO THE EDITOR.

WHERE ARE THE POLICE?

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your attention has doubtless been called to a new patent medicine, said to have been derived from ancient Egypt. Marvellous virtues are claimed for it, and it is retailed to the public at one shilling and a penny per box. Now when one looks at the way this nostrum has been advertised in the public newspapers, it is evident that an enormous sum must have been already spent in advertising. Its broadsheets are signed by a name that suggests some sort of a connection with other more or less notorious quack remedies. To the ordinary medical man this pernicious trade venture is a cruel and fradulent imposture, to be paid for in the long run with tears and blood by a deluded public. How is it that newspapers with any claim to respectability can descend to take money from these rogues? How is it that Scotland Yard and the Home Office permit such frauds to go unchecked? There is hardly one of these notorious quack remedies, which have brought millions of money to their owners, that could not be successfully prosecuted for conspiring to obtain money under false pretences. Where are the police?

Yours faithfully,
AN IRATE PRACTITIONER.

Brighton.

OBITUARY.

PROFESSOR CHARLES STEWART, LL.D., F.R.S.

BY the decease of Professor Charles Stewart, F.R.S., which occurred on Friday last, after a somewhat protracted illness, the Royal College of Surgeons of England has lost an official who has held the office of conservator of the museum for the past 23 years.

After attending as a medical student at St. Bartholomew's Hospital, Professor Stewart obtained the qualification of membership of the Royal College of Surgeons in the year 1862. He was admitted a Fellow of the Linnean Society in 1866, and became President of the Society during the years 1890 to 1894, and in the following year served as Vice-President. Professor Stewart was also a Fellow and Vice-President of the Royal Microscopical Society, and became one of its honorary secretaries in the year 1878. He was treasurer of the Anatomical Society of Great Britain and Ireland from its foundation until 1891. During the period 1894-1897 he held the office of Fullerian Professor of Physiology at the Royal Institution, and delivered several evening lectures at the same place. He was admitted a Fellow of the Royal Society in the year 1896, and obtained the Honorary LL.D. of Aberdeen University.

Before being appointed Conservator of the College of Surgeons' museum, Professor Stewart was Curator of the museum of St. Thomas's Hospital, Lecturer on Comparative Anatomy, and Joint Lecturer with Professor John Harley, on Physiology at that institution. He was subsequently appointed Professor of Biology and Physiology at Bedford College. In the year following his appointment at the College of Surgeons he was elected Hunterian Professor of Human and Comparative Anatomy, and held this lectureship until the year 1894.

The true value of Professor Stewart's scientific work is not to be judged solely by his writings, which, in spite of the vast extent of his knowledge gained from personal observations, were comparatively few in number, but it is to be seen rather on the shelves of the college museum in the unrivalled series of preparations and dissections by which he sought, in continuation of the work of previous conservators, to illustrate important phases in the evolution of the organic world, and thus to amplify the original scheme of John Hunter, whose collection forms the nucleus of the college museum. Professor Stewart was also a master in the art of lecturing. His easy and lucid style, combined with a rare power of swift and effective drawing on the blackboard, would have made his lectures notable, quite apart from the peculiar personal charm of his delivery.

FRANK J. LOCHRANE, M.D., Ch.B.Glasg.

WE regret to record the death, which occurred on September 21st at Derby, of Dr. Frank J. Lochrane, after a few weeks' illness. Dr. Lochrane, who was only 29 years of age, showed great promise as a member of the profession. He was a native of Glasgow, and studied at the University in that city, at Edinburgh, Vienna, London, and Dublin. He graduated M.B. and Ch.B. in 1901, and three years later took his M.D. degree. His first appointment after qualifying was that of house physician and surgeon at Glasgow Royal Infirmary, and he afterwards became house surgeon at Peterborough Hospital. He went to Derby in 1905, being appointed house surgeon at the Women's Hospital on the death of Dr. Henderson Pounds, to whose private practice he also succeeded. A few months ago he was elected a member of the honorary staff of the Derbyshire Royal Infirmary, in the capacity of gynæcologist. He was unmarried.

REVIEWS OF BOOKS.

ULCERATION OF THE CORNEA (*a*)

In writing a book such as this the author gives us good evidence, if any were needed, as to how our bacteriological knowledge of ulcers of the cornea is maturing. While not failing to give a good clinical picture of each form of ulceration, Dr. Macnab devotes most of his efforts to establishing, as far as possible, a classification of corneal ulcers founded on the bacteriological findings and the treatment he has found most suitable for each.

In Chapter I. we find the usual methods of examination described. Dr. Macnab gives a preference to Hartnaek's loupe, but we think Berger's after a short trial becomes very easily managed, and has the advantage of leaving our two hands free to manipulate a lens for oblique illumination and fixing the lids. He tells us the sensibility of the conjunctiva, lid margins and cilia is greater than that of the cornea, and on page 25 "it must be noted that the sensibility of the cornea is not very acute, and certainly is quite dull when compared to that of the conjunctiva and lid borders." These are pronouncements hard to reconcile with clinical and personal experience. In Chapter III. hypopyon keratitis, or pneumo-coccal ulcer, as Dr. Macnab prefers to call it, is fully described, a translation of Saemisch's description being given. The possibility of anterior synechia taking place without a complete perforation of the cornea, due to the perforation of Descemet's membrane, is pointed out as a fact. Some of the difficulties of the diagnosis and the study of the life history of the pneumoccus are here given. For the active treatment of the infiltrated margin of the ulcer Dr. Macnab advises either the electric cautery or pure carbolic acid, but before doing so he lays stress on the importance of thoroughly scraping away sloughs and loose epithelium to facilitate the complete and direct application of the cautery.

Ulcers due to streptococcus, pyocyaneus, Friedlander's B., B. coli commune, staphyloccus, etc., are considered in Chapter IV. In subsequent chapters we find ulcers due to infection from the various forms of specific conjunctivitis, Mooren's and Zur Nedden's ulcers described. Chapter X. is a useful one. It takes us over the bacteriology of organisms found in corneal ulcers.

In the last chapter are described the operations for removal of the lacrymal sac, Saemisch section, and what the author has christened the "Corneal Plastic Operation." In treating of the first-named operation Dr. Macnab does not give any advice as to the anæsthetic used. He refers to the troublesome hæmorrhage generally met with, and advises as a remedy for it the use of the Müller and Axenfeld retractors. These are undoubtedly indispensable, but we cannot say that they always act as efficient controllers of the blood flow, whereas, we have reason to appreciate the good results of subcutaneous injections of cocain, or eucain, and adrenalin both as to anæsthesia and bloodlessness. The corneo-plastic operation, more recognisable as Kuhnt's transplantation of conjunctiva, is well described, and is deserving of more general use as a preventative of staphyloma corneæ and in hastening the process of healing.

There are a few errors that are inexcusable, perhaps, such as the spelling of Mr. Priestley Smith's name and that of Professor Uhthoff, but these by no means forbid a full welcome being given to Dr. Macnab's efforts to lead us on to a more scientific knowledge and classification of corneal ulcers.

RECTAL DISEASES (*a*).

We have received for review the third edition of Mr. Harrison Cripps' well-known work on diseases of the rectum and anus. The book also includes the fifth edition of the Jacksonian prize essay on cancer of the rectum. This portion of the book has been rewritten, and to it has been added a table of 380 consecutive cases which occurred in Mr. Cripps' private practice. The book as a whole furnishes a most valuable monograph on rectal disease.

The author's comments on the value of a speculum as an aid to diagnosis of rectal disease, especially when used in the surgeon's consulting room, is short and to the point:—"It will generally end in a fluid motion on your couch, and the rapid vanishing of the patient who is seldom reclaimed." We should like, however, to find some reference to the sigmoidoscope. If this instrument is of no value for diagnostic purposes, then this fact should be stated as a guide to Mr. Cripps' readers. If it is of value, then a description of its working might with advantage be included. Personally we regard it as calculated to be of as great value in these cases as is the electrically-lighted cystoscope in cases of disease of the bladder.

As is proper, the nature and treatment of the various forms of hæmorrhoids receives full attention, as do such subjects as prolapse, abscess, fissure, stricture. In discussing the treatment of pruritus ani, the operation for this distressing condition devised by Sir Charles Ball has not received the mention to which its novelty and value appear to entitle it.

The Jacksonian essay on rectal cancer which has been added in the present edition, and which can also be obtained as a separate publication, occupies the last nine chapters of the book. A long chapter is devoted to the etiology of rectal cancer, and as the etiology of this form of cancer differs in no particular from that of any other form of cancer, the chapter is practically devoted to the etiology of cancer wherever it may occur. This involves a great deal of discussion, which, however much it may have been suitable in the case of a prize essay, is, we cannot help thinking, entirely out of place in a work on rectal diseases. As well might the chapter on rectal abscess be prefaced by a long discussion on the nature and source of pyogenic organisms. Mr. Cripps' book is of quite sufficient length and importance to enable all unnecessary matter to be dispensed with, and therefore we should like to suggest that in a subsequent edition its size be somewhat curtailed by the exclusion of such matters as the etiology of cancer.

EYE INJURIES (*b*.)

This volume comprises post-graduate lectures delivered by Dr. Ramsay which have been rewritten, and are now published "in the hope that they may prove helpful to general practitioners." Their scope being clinical, all discussion of theories has, as far as possible, been avoided. One is at once struck by the handsome way in which the book is produced—the paper being unusually rich, the print large, and the illustrations, of which there are about sixty, some coloured, are unusually beautiful. Dr. Ramsay has a nice clear style, and makes his remarks interesting by the relation of cases which have come under his observation. The advice given to the general practitioner is reliable, and cannot but be of service to those readers for whom it is mainly meant. We are glad to see in Chapter VI. that Dr. Ramsay has had experience of injecting argyrol into the anterior chamber of eyes which have become infected from perforating wounds, those desperate cases that call

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(*a*) "Ulceration of the Cornea." By Angus Macnab, B.A., B.Sc., M.B., Ch.B., F.R.C.S. Pages xiv., 196. 20 illustrations. London: Ballière, Tindall and Cox. 1907. Price 5s.

(*a*) "On Diseases of the Rectum and Anus, Including the Fifth Edition of the Jacksonian Prize Essay on Cancer." By Harrison Cripps, F.R.C.S., Senior Surgeon to St. Bartholomew's Hospital, &c., &c. Third edition. London: J. and A. Churchill. 1907.

(*b*) "Eye Injuries and Their Treatment." By Maitland Ramsay, M.D. Pages 210. Plates 25. Glasgow: James Maclehose and Sons. 1907. Price 18s.

for prompt and radical treatment. The reviewer's experience is limited to one case where panophthalmitis was fully expected. A few drops of 5 per cent. argyrol injected into the anterior chamber acted so quickly that next day the hypopyon had disappeared, the pupil was well dilated and chemosis and pain were gone. After removal of the soft lens useful vision resulted.

In diagnosis of sympathetic irritation the author lays stress on the spindle shaped enlargement of the blind spot as demonstrated by Bjerrum's screen. He takes this sign to mean congestion of the optic disc. At the same time a low degree of myopia may be present. Without wishing to account for these signs Dr. Ramsay tells us that they disappear on removal of the exciting eye. Reading on we come to sympathetic inflammation, and we find ourselves in a technical discussion as to its pathogenesis. Six rules afford reliable and concise guides as to when to enucleate and when not to enucleate.

Dr. Ramsay does not approve of the modern tendency of confining ourselves to local treatment only, with which we are quite in accord, but we think he goes somewhat far in the opposite direction in the following:—"Again, in a case of keratitis, most gratifying results are often obtained by following the old-fashioned plan of blistering the eyelids with solid caustic; and in iritis, when the disease is tending to relapse time after time, the application of a blister often brings about such a change that recovery goes on afterwards without interruption. A more pronounced result still is obtained if the blistered surface be kept open by the application of an irritating ointment or by D'Albespeyre's paper, and in all deep-seated chronic inflammation an open blister contributes largely to the means of a cure. When the inflammation is due to syphilis, the presence of an open sore is, in my experience, most helpful, and therefore, in such instances, I have not the slightest hesitation in inserting a seton in the nape, and keeping it there for several months. So strongly, indeed, am I convinced of the value of such measures that I feel that those who do not fully avail themselves of them deprive their patients of an important source of help."

Inasmuch as most general practitioners have their own ideas as to what an "Alterative Pill" or "Iron Pill" ought to be, we think the sixty pages devoted to the Pharmacopœia of Eye Diseases might have been curtailed considerably. We congratulate Dr. Ramsay on the masterly work he has produced and his publishers on the way in which they have accomplished their part.

PRACTICAL ANÆSTHETICS (*a*).

THE author states that the object of this little book is to furnish a short guide to those who have not the leisure to study other large manuals on the subject. The work is divided into eight chapters, and runs into over 170 pages. When a surgical operation has to be performed we consider the selection of an anæsthetic and its administrator is all-important—sometimes far more important than the operation itself, as regards danger to the patient. It is very pleasant indeed for a patient about to undergo a serious surgical operation to be able to sink calmly and safely into the mysterious sleep of insensibility, trusting only in the goodness of his Maker and the skilful knowledge of his operator and anæthetist. Practitioners too often are called on in a hurry to administer an anæsthetic for an emergency operation, and frequently without much special knowledge of the subject. We consider no one should be allowed to adminster an anæsthetic unless such a person has had some preliminary training in the administration of all descriptions of anæsthetics in a hospital, under the direction and supervision of a skilled anæsthetist. The author describes the many difficulties and dangers of anæsthesia, and gives much practical information to the beginner, as regards what to do, and what to avoid. He does not appear, however to be aware that the ether inhaler, so often called by Clover's name, was in reality a modified copy of the original ether inhaler, adapted by Ormsby, of Dublin.

We advise all who either now adminster anæsthetics or who hope to do so, to purchase this little book, as it will give them many useful hints on the subject.

LECTURES ON CLINICAL SURGERY (*a*).

WE have read through these practical clinical lectures and addresses, which the author tells us have already appeared in the columns of the *British Medical Journal* and the *Clinical Journal*. They are printed as they were delivered, in rather a colloquial style, so as to emphasise the lecturer's meaning to his class. The lectures comprise such practical subjects as: The Course of Intra-abdominal Inflammation, on the Recognition and Management of Intestinal Obstruction, Carcinoma of the Breast and its Spread into the Lymphatics, Varicose Veins, etc. The lectures are not only interesting and practical, but are most readable, and many a young operating surgeon or general practitioner will derive a great deal of sound useful information from their perusal, which will be of service to him in his practice, where difficult and doubtful cases come before him.

GOUT (*b*.)

THE third edition of this well-known work hardly calls for a detailed notice. It is written in the clear and lucid style that one has learned to associate with all that comes from the author's pen. Yet the book does not simply mark time in our scientific attitude with regard to gout. Dr. Luff herein (p. 64) formally abandons his theory of the renal origin of the malady, with which his name has been so long associated, and he now adopts the view that a bacterial toxin is probably the primary cause of gout. This change of opinion serves to illustrate the obscurity that still surrounds the etiology of this important disease. For our own part we are inclined to think that hardly enough stress is laid by investigators upon the *tertium quid* in the shape of some peculiar predisposition in the constitution of the patient. In discussing treatment we note that the use of the galvanic current is advocated in conjunction with massage in order to promote absorption of œdematous infiltration and deposits. Similarly cataphoresis of gouty joints with potassium bicarbonate or lithium iodide is advised. The local electrical treatment of gout is a branch of therapeutics that deserves more attention that it receives at present from medical men. Patients suffering from acute or subacute attacks of gout are warned against resorting to the Turkish bath. The book is well published, it goes without saying, and it is the plain duty of every physician to master its contents.

TUBERCULOSIS, THE REAPER. (*c*.)

THE fact that this popular treatise on the tuberculosis problem has now reached a second edition after having been widely distributed throughout France by the order of the Minister of Public Instruction affords ample evidence that the work at least has been appreciated, and it may be hoped will prove of lasting service to the people of France. It is clear that if tuberculosis is to be eliminated from civilised countries, it can only be by the instruction of the masses and the acquiescence of citizens, and particularly of parents in the practical conduct of such anti-tuberculosis

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(*a*) **"Practical Anæsthetics." By H. Edmund G. Boyle, M.R.C.S., L.R.C.P. Assistant Anæsthetist to St. Bartholomew's Hospital, etc., Oxford Medical Publications. Illustrated. Pp. 178. Published by Henry Frowde, Oxford University Press, Amen Corner, E.C., and Messrs. Hodder and Stoughton, Warwick Square, London, E.C. 1907. Price 5s. net.**

(*a*) **"Clinical Lectures and Addresses on Surgery." By C. B. Lockwood, Surgeon to St. Bartholomew's Hospital, London. Oxford Medical Publications. Illustrated. Pp. 275. Published by Henry Frowde, Oxford University Press, Amen Corner, E.C., and Messrs. Hodder and Stoughton, Warwick Square, London, E.C. 1907. Price 5s. net.**

(*b*) **"Gout: Its Pathology, Forms, Diagnosis, and Treatment." By Arthur P. Luff, M.D., D.Sc., Physician to St. Mary's Hospital. Third Edition. Cassell and Co., London and New York. 1907. 10s. 6d. net.**

(*c*) **"La Grande Faucheuse: vade-mecum de l'Education Anti-tuberculeuse dans la famille, à l'école, à l'atelier." By Dr. Fernand Barbary. Pp. xi.-340, with 46 figures. Second Edition. Paris: F. R. de Rudeval, 4, Rue Antoine Dubois. 1907. Price, 7 francs.**

measures as Dr. Barbary so well enunciates and explains in his manual. The work is constructed on common-sense lines and can be readily followed by any intelligent layman. In a simple but forcible manner, he explains the nature, causation; pathology, and clinical manifestations of pulmonary tuberculosis and discusses the principles of prophylaxis and treatment in a manner more adapted for the physician than the man in the street. The book is perhaps more suited to the family practitioner than to the unscientific head of a household. Particulars are given of a number of sanatoria, and climatotherapy and the use of mineral waters are discussed. In the closing chapter the anti-tuberculosis campaign as conducted in France is briefly described. There are a number of illustrations, and two maps roughly indicating the geographical situation of the chief sanatoria in Germany and Belgium. Although there is a table of contents, there is, in accordance with the unpardonable custom of French authors, no index.

MATERIA MEDICA AND PHARMACY. (*a*)

This remarkably compact and well-digested compendium of materia medica and therapeutics is such an old friend that comment is almost unnecessary. This edition has been carefully revised and brought up to date, and this is especially the case in respect of organotherapy, even that interesting departure in treatment, the employment of the now famous opsonic index, receiving a full meed of attention. We would respectfully urge the author to abandon the use of the term "tubercular" (which is, strictly speaking, an anatomical term) in lieu of "tuberculous," *e.g.*, derived from tubercle.

The work will be found an extremely convenient work of reference by practitioners, more particularly now that the study of materia medica and therapeutics has unhappily been placed in the background of medical education. Prescribing, it has aptly been remarked, is becoming a lost art, and many medical men affect scepticism in regard to the use of medicinal agents, mainly on account of the difficulty they experience in handling them—an art that is of the highest importance in the daily routine of practice, as much as, indeed, a knowledge of anatomy and physiology. The latter, indeed, are but the means to an end, and that end is therapeutics. Patients want to be *treated*, and diagnosis, after all, is, or should be, only a preliminary step in that direction.

WRIGHT'S MEDICAL ANNUAL.

This useful publication is so well known to the profession and so justly valued, that there is little need for comment on each successive issue. This year's number contains some sixty pages more than that for 1906, and the number of contributors is also a little increased. Among the new contributors are Mr. Sampson Handley, who discusses cancer in a notable article, an excellent summary of present knowledge on the subject; Mr. Robert Jones, who writes on Nerve Anastomosis and Nerve Grafting; Dr. Batey Shaw, who writes on Diseases of the Ductless Glands, and Dr. Whitridge Williams, who writes on the Toxæmias of Pregnancy. It will be seen that the editors spare no pains to obtain writers of special authority in their various subjects. We have tested the book on many points, and while noting a few omissions, we have failed to find any serious flaw. As is almost inevitable, there is a certain lack of proportion between the different articles, and a certain want of uniformity of treatment. Some writers give mere abstracts of recent literature, while others contribute critical articles of original value. Taken altogether, however, the book is invaluable to the general practitioner, as he has long ago learnt. We deprecate the tendency to increase the bulk of the book, though, as the price remains the same, it would be ungrateful to grumble.

THE SIGMOIDOSCOPE. (*a*)

This little book gives a good working description of an instrument which ought to be in far greater use than it actually is. The form of sigmoidoscope which the author recommends is that originally devised by Professor Strauss, and which he has slightly modified. He emphasises the importance of obtaining the proper and best pattern when purchasing an instrument, as there are several poor imitations of it on the market.

Having described the mode of using the instrument, the author proceeds to describe the appearances seen by its aid in various pathological conditions. There are also several illustrations, which, however, would be of more value if they were coloured, but we presume the increased cost would be too great for a book which must necessarily meet with only a limited demand. We can cordially recommend the little work to any one who is desirous of acquiring a knowledge of the mode of using a useful instrument.

PALMER ON MASSAGE. (*b*)

The appearance of the third edition of this book testifies to its excellence as a handbook. The wide experience of the authoress in the massage department of the London Hospital has taught her what are the essential points required by a learner of the act. Accordingly we find a reference to anatomy and physiology that is sufficiently full without being burdened with unnecessary details. There we may see good illustrations and tables, and chapters are added on the Nauheim treatment and massage of children. On the whole this is one of the best special works of the kind with which we are acquainted, and a nurse requiring a handbook of massage would do well to choose a Palmer's book.

Plague at Oran.

Plague has broken out at Oran. According to the Paris papers, there have already been two deaths, one of a porter, and the other of the wife of a railway official. The number of cases in one journal is reported as four, and in another as 11. The centre of infection is in the store sheds of the Chamber of Commerce, where the victims were at work, and where rats are said to have been found. Admiral Philibert has announced that all war and transport ships belonging to the State have left Oran and proceeded to Mers-el-Kebir. The base of operations has been transferred from Oran to Algiers.

Notification of Births.

The Local Government Board have just issued a circular to local authorities explaining the new Notification of Births Act. The object of the measure, which will only be in operation where it has been adopted by the local authority with the consent of the Board, or has been declared to be in force by the Board, is to provide a speedy means whereby information of the birth of a child may be given to the medical officer of health of the local authority, so that, if necessary, advice may be given to the mother in regard to the rearing and nurture of the child. The Board observes that there is no occasion for imposing upon parents and others the obligation of notifying births in the special manner provided by the Act unless steps are taken to carry out the ultimate object of the measure, viz., the giving of advice and instruction to those who have charge of the infants, and in ordinary circumstances the Board would not be prepared to consent to the adoption of the Act unless it appeared that arrangements had been made for this purpose. These arrangements would usually be best carried out by local agencies under the medical officer of health. The Board trusts that the local authorities will consider the question of adopting the Act and of co-operating with any agency that may exist, so as to secure its successful operation.

(*a*) "Materia Medica, Pharmacy, Pharmacology, and Therapeutics." By W. Hale White, M.D., F.R.C.P., Physician to and Lecturer on Medicine at Guy's Hospital, &c. Tenth Edition. Price 6s. 6d. net.

(*a*) "The Sigmoidoscope: A Clinical Handbook on the Examination of the Rectum and Pelvic Colon." By P. Lockhart Mummery, B.C. Cantab. F.R.C.S.Eng. London: Bailliere, Tindall and Cox. 1906. Pp. 86. Price 5s. net.

(*a*) "Lessons on Massage." By Margaret D. Palmer. Third Edition. London: Bailliere, Tindall and Cox, Henrietta Street, W.C. 7s. 6d. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT PATHOLOGICAL LITERATURE.

Howell's Granules.—In 1890 Howell pointed out that in the blood of cats following a hæmorrhage large numbers of the red corpuscles may contain a single good-sized piece of nuclear matter, too large to be called a granule, and having the shape and appearance of a large nucleolus. Since that time other observers have studied them, and doubt has been expressed as to whether they were nuclear in origin, or merely basophile granules, such as are met with in many forms of anæmia. Morris (*Johns Hopkins' Hospital Bulletin*, July, 1907, page 199) now describes them for the first time as occurring in human blood, in various cases, such as typhoid fever and pernicious anæmia. He has also found them in the blood of two fœtuses, and believes that they appear always in association with increased blood formation. As found in the blood of rabbits poisoned with pyrodin, he describes the structures as round or oval in shape, and almost invariably eccentrically situated in the containing corpuscle. The outline is well defined, and occasionally there is noted a paler zone in the protoplasm of the cell surrounding the nuclear particle. Unlike basophilic granules, they take up a purple colour like that of the nucleus with Romanowski's skin. M.

Cephalic Tetanus.—Friedlander and Meyer have observed a case of cephalic tetanus (*Deutsche Med. Woch*, 1907, No. 28) in which the spasms and paralysis remained limited to a very small muscular region, but in which the intensity of the disease was nevertheless great. The duration of the period of incubation and the entire course of the disease were very long, but the case ultimately ended fatally. The facial paralysis was very distinct, and involved the abducent, the oculo-motor, and the trochlear nerves, as well as the facial nerve itself. The authors consider the various possible causes of this paralysis, and conclude that the most likely underlying pathological change is an ascending neuritis. M.

Orthostatic Albuminuria.—According to the investigations of Porges and Pibram (*Deutsch Archiv. fur Klin. Med. Bd.* xc., p. 367) it is probable that orthostatic albuminuria is caused by changes in the kidney circulation. General influences, such as changes in the general systemic circulation, appear to be without any real influence. Amongst the local conditions which lead to venous stasis in the kidneys they include an increase in abdominal pressure caused by changes in the position of the body, and changes in the position of the kidneys themselves. They believe also that spasm of the small arteries of the kidneys may in many cases also cause albuminuria. The knowledge that such spasm is present in the living is of course only obtained indirectly, and is, as a rule, merely the result of exclusion of other causes. M.

Vaquez Disease.—Hnàtek (*Casopis likaru ceskvet*, 1907, p. 687) has investigated a case of idiopathic polycythæmia occurring in a labourer aged 56, who had suffered during three years from dyspnoea, giddiness, and a dark red colour in the face. As a child he had suffered much from epistaxis and hæmorrhage from other mucous membranes. Objectively one found marked facial cyanosis; the mucous membrane of the mouth of a deep red colour; marked carotid pulsation; dilated superficial veins; blood pressure 150 m.m. Hg.; and a splenic tumour extending down as far as the crest of the ilium. The number of red cells was fourteen million per c.m.m.; the hæmoglobin reached 188 per cent.; and the white cells 36,000 per c.m.m. The urine was highly albuminous, After a period of three months no change was found in the condition. The author discusses the etiology, and suggests that it may be due to defective destruction of red cells, owing to an absence of the suprarenal secretion. Experimentally, injections of adrenalin have been found to cause extensive blood destruction. Various remedies were made use of in the case, but without avail. M.

Blood Formation in the Liver and Spleen.—During fœtal life the liver and spleen have hæmopoietic functions, and pathologically during adult life it seems likely that they resume these functions, as, for example, in pernicious and other severe anæmias. In order to ascertain whether such a reversion in function can be induced experimentally, Morris has produced anæmia in rabbits. (*Johns Hopkins' Hosp. Bulletin*, July, 1907, page 200, etc.) by the subcutaneous injection of pyrodin. The conclusions at which he arrives are as follows:—(1) The anæmia caused by pyrodin is one with a high colour index, and results from injury to certain of the red cells, which are then removed from the circulating blood by phagocytes in spleen, bone-marrow, and liver. (2) The increased blood destruction leads to compensating increased formation. (3) Heightened activity of the hæmopoietic functions of the bone-marrow is met with, and myeloid elements occur in the spleen and occasionally in the liver. (4) The changes in liver and spleen are similar histologically to those seen in normal rabbits' embryo. From this it seems likely that the spleen and liver had resumed their hæmopoietic function. (5) Hæmosiderosis of organs occurs as in pernicious anæmia. M.

Phagocytic Action of the Alveolar Cells.—Briscoe (*Journal of Pathology and Bacteriology*, October, 1907) reports a very elaborate investigation of the nature and functions of the alveolar cells of the lungs. The following are the more important of his conclusions:—(1) The mononuclear cells of the alveoli are powerful phagocytes. (2) The phagocytic action of these cells depends on an opsonin. (3) With a mild infection, by the help of an opsonin, and without the aid of leucocytes, the alveolar cells can free the lungs of organisms. (4) If the infection is more virulent, the leucocytes give active assistance. (5) Phagocytosis is more rapid when the animal infected has been previously immunised than when a normal animal is employed. (6) For some time after infection phagocytosis is limited to the alveolar cells. (7) The bronchioles, not being lined with phagocytic cells, are at a disadvantage as compared with the alveoli in regard to an infection spreading downward. R.

An Anti-Gonococcic Serum.—Rogers and Torrey (*Journal of the American Medical Association*, September 14, 1907) report the mode of preparation of, and the results of treatment by, an anti-serum for gonorrhœa. Rabbits were at first used for preparing the serum, but as it was found that rabbit serum, though sufficiently potent, might also be very toxic, sheep were afterwards substituted. Full-grown rams were found most suitable, and ten injections were given intra-peritoneally. The first inoculation consisted of the twenty-four surface growth from eighteen square inches of solid culture medium, emulsified in about 30 c.c. of physiological salt solution, and heated for half an hour at 65 deg. C. After an interval of about a week the second injection was given, consisting of the growth from about thirty square inches, emulsified and heated as before. The third inoculation consisted of about eighteen square inches of *unheated* growth, and thereafter increasing doses were given up to a maximum of about forty-five square inches of unheated growth. After nine or ten inoculations, a little blood was drawn and tested for agglutinins. If agglutinins were present in quantity the animal was regarded as highly immunised, and it was bled to death, the serum being collected. The gonococcus used for making the inoculations was of mixed strains, with the view of producing a polyvalent serum. The serum was administered in doses of about 2 c.c. each. The authors do not regard the serum as having any potency toward acute gonorrhœal lesions, such as acute urethritis, and they do not advise its use in such cases. They furnish sufficient clinical reports as to its use in more chronic gonorrhœal infections, such as arthritis, gleet, cystitis, leucorrhœa, to justify a further trial. The criticism is to be made that the authors do not establish the specificity of the serum as an anti-serum to gonorrhœa. They by no means exclude the possibility, which they do not perceive, that the curative effects of the sheep's serum may be due, not to the action of an anti-serum, but to a vaccination. We do not find any experiments to show that the serum as actually used was sterile of gonococci. Moreover, the therapeutic effects are very similar to those of vaccination by dead gonococci. R.

Causation of Atheroma.—Rickett reports (*Journal of Pathology and Bacteriology*, October, 1907) a series of experiments on the causation of atheroma. It had previously been pointed out that the prolonged administration of adrenalin was almost invariably followed by atheroma of the arteries, and it had been held that this result was due to a toxic action of the adrenalin on the vessel walls. In opposition to this, Rickett held that the cause of atheroma was purely mechanical, viz., the continued high blood-pressure. To put the matter to the test, he tried the effect on the vessels of rabbits of the continued injection of other drugs which have similar effect to adrenalin as regards blood-pressure, though differing from it and from each other in most other respects. With squills, with barium chloride, with tobacco, and with nicotine, Rickett succeeded in producing an atheromatous condition of the vessels. That this change was not due to a merely irritant action seems to be established by the failure to produce it by the continued intravenous injection of potassium cantharidate. This drug was chosen because, though highly irritant, it causes no rise of blood-pressure. R.

Origin of Rodent Ulcer.—Noon (*Journal of Pathology and Bacteriology*, October, 1907) discusses briefly some of the views which have been held regarding the point of origin of rodent ulcers. His seven observations support the doctrine that this form of tumour starts in the malpighian layer of the epidermis, near the necks of the hair follicles, and from the reflection of this layer, which forms the outer root sheath of the hair. He furnishes plates which would be difficult to reconcile with any other opinion. At the same time, the possibility is admitted of another form of tumour, which clinically would be regarded as rodent ulcer, originating in the epithelium of the sweat-glands. No notice, however, is taken of the modern suggestion that rodent ulcer is an endothelioma of the superficial lymphatics. R.

MEDICAL NEWS IN BRIEF

Royal Academy of Medicine in Ireland.

THE annual general meeting of the Royal Academy of Medicine in Ireland will be held in the Royal College of Surgeons, on Friday, October 11th, 1907, at 4.30 p.m., when the annual report will be submitted, and the officers and members of Sectional Councils will be elected. The offices for which candidates may be nominated are:—General Secretary and Treasurer; Secretary for Foreign Correspondence; Presidents of the Sections of Obstetrics, Pathology and State Medicine; Member of Council in the Sections of Medicine, Surgery, Obstetrics, Pathology, Anatomy and Physiology, and State Medicine. A Fellow is ineligible for election on more than two Sectional Councils. No Fellow can be a candidate for election on both Medical and Surgical Councils.

Deportation of an English Lady from America.

A SAD case of suicide and homicidal mania has just transpired by the return to England on the White Star liner "Adriatic," which arrived at Southampton from New York, of a young English lady evidently well connected and with ample means. She is said to be the daughter of a millionaire London banker, and arrived in New York on the "Oceanic" on May 31st last. The poor lady's conduct during the outward voyage was so strange that she was taken to the private sanatorium of Dr. Curtiss at Flushing, Long Island, near New York, where, however, she did not improve in health. On the contrary, she became worse, and ultimately the most luxurious suite on the "Adriatic" was engaged for her, and with an army of attendants and nurses she was taken on board and given in charge of the Commander, Captain E. G. Smith. Painful scenes of violence and an attempt at suicide were made by the afflicted lady prior to the sailing of the ship. The Immigration Commissioner of New York refuses to discuss the case, and would not say whether or not she was being deported by the Immigration Authorities.

A Supreme National Health Authority.

THE proposal has been thrown out that a preliminary conference of the representatives of the Sanitary Committees of the County Councils, County Boroughs, and Municipal Boroughs (Metropolitan and Provincial) and Port Sanitary Authorities of England and Wales, shall be held in London on November 13th, 14th, and 15th, for the purpose of considering the question of the establishment of a permanent Union of the Sanitary Authorities of the Kingdom into a Supreme National Health Authority. As we said last week, the absence of uniformity of action on the part of sanitary authorities generally in furtherance of questions concerning the public health of the country has been recognised for a long time past, and, on account of the diversity of the interests involved, has hitherto been regarded as an almost insurmountable difficulty as well as a cause of much waste of energy and time in attempts to carry out broad measures of sanitary reform. This difficulty may, it is thought, be minimised, if not entirely overcome, by a combination of the respective bodies into one great whole for the consideration and treatment of the hygiene of the nation at large. Many sanitary authorities have already undertaken to send representatives to the conference, and favourable replies have been received from a large number of others. The Chairman of the Executive Committee is Alderman Dr. H. W. Newton, of Newcastle-upon-Tyne, and Mr. Henry E. Armstrong, Medical Officer of Health for Newcastle-upon-Tyne, is hon. secretary.

Bristol Royal Infirmary.

THE *Bristol Medico-Chirurgical Journal* contains some strong comments on the new rules adopted at the Bristol Royal Infirmary. "By what right," says the editor, "do the committee or the governors of the Royal Infirmary presume to dictate to their honorary physicians or surgeons how they shall occupy their life apart from their duties to the Bristol Royal Infirmary? The living governors and their lay committee have neither built nor endowed the institution, and are mainly the inheritors of the generosity of bygone ages, to which they add their quota. So with the medical staff. Here, as elsewhere, they have not made the prestige of the Royal Infirmary; they inherit it from their medical forefathers, but they, too, add their quota to the good repute. The governors inherit the buildings and endowment, and it is theirs to maintain; but so, too, the medical profession inherit the medical prestige, and that is theirs to maintain. But, alas! and here is the pity, the lay governor, realising that there is a prestige attaching to his hospital, considers it is his to manipulate even to the detriment of the medical staff. If you serve our institution, they say, you must have your charitable wings clipped and go lame. You medical men have duties to perform in our hospital, and it is not enough that these are faithfully and honourably discharged. It is not enough that your forefathers have so raised the prestige of our hospital that we can, and do, insist on your having the highest qualifications, and practising as pure physicians, surgeons, and specialists—that you have suggested yourselves because it appeared a real advantage to the institution—but, notwithstanding this, we compel you, whether you like it or not, to accept terms which are vexatious, if not derogatory, by binding you to forego any other charitable effort, or to accept any remunerated office usually held by consultants. In your young years you may waste your spare time in any way you wish, but one thing you shall not do. You shall not, in your keen love of your profession, serve another hospital, to gain experience outside our walls, that you may become better physicians or surgeons. . . . We do not suppose for a moment that the generous and honourable laymen of our hospitals are capable of deliberately injuring or slighting their staff. It must surely be misconception only that induces them thus to forget what they owe to the medical profession, for medical science is undivided, and is not only national, it is international. If the medical work at British hospitals is to be honorary, let it be continued as the charity of the whole medical profession; otherwise, it should be treated on true business lines, and duty paid for like the buildings, food, and nursing. Let us wake up, and see that the laymen do not exploit the profession, and ruin our work with their so-called 'business principles.' The blow is none the less hurtful because it is dealt by friends."

St. Bartholomew's Hospital New Buildings.

THE site of this ancient institution has recently been extended by the purchase of one and a half acres of adjoining land from Christ's Hospital. The foundation-stone of the first new block of buildings was laid by His Majesty the King in 1904, and formally opened by H.R.H. the Prince of Wales, President of the Hospital, in July last, it being ready and in full working order at the opening of the winter session yesterday. The new buildings contain the following accommodation:—The club rooms of the students' union, residential quarters for the house physicians, house surgeons, and other members of the residential staff, and for the maternity clerks during their periods of duty. A separate dining room, with a smoking and a recreation room, are provided for the resident medical officers, and each has his own sitting-room and bedroom. All are conveniently arranged and furnished so as to afford accommodation for the resident staff second to none in the kingdom. Beside these there is a new casualty department, 140 feet long and 45 feet wide, which gives seating accommodation for 850 people; a new medical out-patient department, and a surgical out-patient department, an operation theatre, a dressing and sterilising rooms, etc., have also been added. There are also departments for diseases of women, ophthalmic, and aural cases, and for diseases of the throat and nose. Special accommodation has been also provided for orthopaedic, skin, X-ray, and electrical cases, whilst additional rooms have been set apart for the dental department, and a new clinical lecture theatre, and a new chemical laboratory complete these extensive and ideal premises.

St. Mary's Hospital Medical School, Paddington.

As the result of the examinations for the Entrance Scholarships, 1907, held on September 23rd, 24th, and 25th, the following awards have been made:—Open Scholarships in Natural Science: £145, J. T. S. Gibson, Aske's Haberdashers' School; £78 15s., C. R. Harrison, Balham School; £52 10s., W. B. James, Derby Municipal Technical School; £52 10s., C. E. S. Jackson, Haileybury College. University Scholarships: 60 guineas, H. B. Richmond, B.A., King's College, Cambridge. Exhibition of 30 guineas, P. N. Cave, B.A., University College, Oxford.

Medical Man's Struggle on a Liner.

DR. FRENCH, the surgeon on the White Star liner "Majestic," had an alarming experience during the voyage to New York last week, narrowly escaping from death at the hands of an insane stoker. On the third day out, one of the stokers came to him in his surgery. Dr. French had no reason to feel alarmed at the man's appearance, but was surprised when the latter turned and locked the door behind him. Then, without any warning, the stoker threw himself upon the doctor, hurled him to the floor, and fiercely attacked him. Dr. French was unable to resist the maniac's strength, and could only cry out for help. The stoker held him by the throat, and the unfortunate doctor was being rapidly strangled when one of the ship's officers, finding it impossible to effect a rescue by means of the door, fired a revolver through a grating and shot the lunatic. The man fell back badly wounded, and Dr. French hastily flinging open the door pinned the man to the ground until assistance arrived.

Sanitary Committee.—Notification of Births, Doctors' Objection.

THE General Purposes Committee reported that they considered the advisability of the adoption of the Notification of Births Act, 1907, and that the Town Clerk reported that the Act, which required adoption by the Council with the consent of the Local Government Board, required the father of a child, if residing in the house where it was born or any person in attendance upon the mother at the birth, or within six hours after, to notify the birth to the Medical Officer of Health for the district within 36 hours of the event, the notification being in addition to the ordinary registration of birth. The Act provided that a person should not be liable to the penalty prescribed for non-compliance if he had reasonable grounds to believe that some other person had given the notice, and that the notice might be given by post-cards, which were to be supplied, stamped and addressed by the local authority, free of charge to any medical man and midwife who applied for them.—It was resolved that the Council be recommended to take the necessary steps for adopting the Act.—Mr. Peacock moved the adoption of the report, and Mr. Tonkin seconded.—Dr. Preston King moved that the matter be referred back to the committee for further consideration in order that the opinion of the medical men of the city might be obtained. The adoption of the Act was only optional, and he thought the committee ought to refer it to the Bath branch of the British Medical Association. The Act placed upon the medical men, in the absence of the father, the necessity of notifying the birth, and thus rendered him liable for doing something for which he got not one penny or thanks of any sort. If the Government had simply reduced the time during which notification was required to be made, and retained the machinery of the old Act, which made the father responsible, it would have been all right.—Mr. Tonkin said the Act seemed to him to be a very sensible one. All that was required to be done was that postcards should be sent notifying the birth.—Alderman Vincent seconded Dr. Preston King's amendment.—Mr. Spear said the idea on the part of the committee was that the Act would be adopted. Dr. Symons reported the recommendation then, but now thought it would be better to withdraw it and refer it back on the ground that the medical men of the city objected to writing a postcard and sending it unless they were paid for it. He (Mr. Spear) was not in sympathy with the attitude of the medical profession.—Dr. Ryan said he would be very sorry to think that the medical profession in Bath as represented by Dr. Preston King would stand in the way of such an excellent measure, and he personally would be very sorry to accept anything for the trouble of writing a postcard of that sort. He hoped the matter would not be referred back.—Dr. Preston King said that those words, as coming from another medical man, were hardly justified. He was not speaking personally, but from what he could gather from one or two medical men who were also absolutely impersonal in the matter, because they were not affected by it. Before an Act which was optional was adopted, the persons who were going to be affected by it ought to have the chance of being consulted, and those in question would not have that chance if the Act was adopted that morning. It was not the question of a fee that was the main thing, but the fact that the Act would render medical men liable to a penalty if they did not do certain things. They had a right to be consulted.—Mr. Spear pointed out the duty of sending the card was not thrown upon the doctor primarily, but upon the father, and the doctor was not liable to a penalty if he had reasonable ground for believing that the notice was sent by someone else in the house. The Act had been passed as part of a great question—the question of infantile life in the country. He was glad to know that Dr. Ryan was thoroughly in favour of the proposals.—The Medical Officer said he did not think they should throw upon the medical men the necessity of sending the postcards. His own idea at the time the recommendation was passed by the committee was that it would not call upon the medical men at all. When the Act was before Parliament the idea was that the medical men should not be made liable, but owing to bad faith the clause was included. —Mr. Spear said that any prosecution would have to be first ordered by that committee. They would not be likely to see an injustice done a medical man of the city.—Dr. Preston King's amendment was lost by five votes to four, and the recommendation in favour of the adoption of the Act was then carried unanimously.

Prizes for Mothers.

THE town of Leipzig has resolved to give prizes to mothers who nurse their own babies for a certain length of time. The mothers applying for prizes are under the supervision of doctors, midwives, and certain female clerks of the town orphanage. Midwives who persuade mothers with success to nurse their own children are entitled to a money present.

The Sea Water Cure.

A TRAGICAL ending to an experiment with Dr. Quinton's sea water injection cure has just thrown an aristocratic family into mourning.

Count Victor Benedetti, grandson of the last Ambassador of the Empire at Berlin, and godson of Prince Napoleon and Princess Mathilde, was taking a rest from overwork at Fontainebleau with his father and mother. In spite of their remonstrances, being attracted by the wonderful accounts given of the success of Dr. Quinton's methods, he insisted on trying them. The most minute precautions were taken to obtain the freshest serum, and the operation of subcutaneous injection was performed.

The next day M. Benedetti complained of violent headache, and on the following morning high fever set in. The celebrated surgeon, Dr. Cuneo, was hastily summoned from Paris, and he hoped at first that it might be possible to localise the poisoning, but the strength of the patient was not equal to the vigorous treatment required, and he sank quickly.

It is not yet certain whether the materials used were defective, or whether the constitution of the patient was naturally refractory to a treatment which has certainly produced marvellous results on others, but the case proves that the new remedy is one that, for the present, at least, must be viewed with mistrust.

The Royal University of Ireland.

THE following candidates have passed the undermentioned examinations:—

The First Examination in Medicine.—Pass.—Samuel Acheson, Abraham N. Berman, Mary K. Carroll, Vincent A. Cox, Frederick Crooks, Cuppage Burke, Daniel J. Enright, Samuel R. Foster, George H. Hayes, Thomas Hill, Richard McCulloch, Harold McDonald, Thomas J. R. Maguire, Henry F. Moore, George R. Naylor, Louis J. Power, Joseph Prendivilte, Adiel E. H. Reid.

The following candidates may present themselves for the further examination for Honours in the subjects set after their respective names; those qualified in two or more subjects may present themselves for all:—Vincent A. Cox, Frederick Crooks, Daniel J. Enright, Samuel R. Foster, Thomas J. R. Maguire, Henry F. Moore.

The Second Examination in Medicine.—Upper Pass. —Richard H. Barter, Harold Black, Michael J. Fogarty, Thomas J. Kilbride, Patrick D. McCullen, Stephen A. McSwiney, Michael Moloney, Denis Murphy, Thomas Reynolds, Charles J. Simpson, James Stewart. All the above candidates may present themselves for the further examination for Honours.

Pass.—James T. Brady, Percy M. J. Brett, Francis J. Burke, Louis Cohen, George Cooper, Robert C. Cummins, Thomas A. Daly, Ernest S. Dixon, Herbert Emerson, Thomas Fitzgerald, Philip J. Gaffikin, George S. Glass, B.A., James J. Hanratty, Charles A. P. Harrison, Timothy F. Hegarty, Daniel Higgins, Robert A. Kerr, Alfred J. Moran, Joseph E. O'Sullivan, Gerard Sheridan, William J. Smyth, John Stephenson, Bernard Teeger, Francis J. Wisely.

Exempt from further examination in Practical Chemistry.—Jane L. Law, Mary A. Murphy.

Apothecaries' Hall of Ireland.

AT a meeting of the Court of Directors the following were elected Examiners for the ensuing year:—

Chemistry and Physics.—Prof. Hugh Ryan, D.Sc., F.R.U.I.; J. J. O'Sullivan, L.R.C.P.S., D.P.H. Biology.—Prof. D. J. Coffey, M.D., F.R.U.I.; John Knott, M.D. Anatomy.—Prof. Frazer, M.D., F.R.C.S.; P. J. Fagan, F.R.C.S. Physiology.—Prof. D. J. Coffey, M.D., F.R.U.I.; John Knott, M.D. Medical Jurisprudence.—W. Fottrell, L.R.C.P. and S.I.; J. C. McWalter, M.A., M.D., D.P.H. Pharmacy.—J. A. Walsh, L.R.C.P. and S.Edin.; J. C. McWalter, M.A., M.D., D.P.H.; E. F. Hanrahan, M.B., B.Ch. Materia Medica.—John Evans, L.R.C.S.I.; John D. Crinion, L.R.C.P. and S. Pathology.—J. L. Keegan, F.R.C.S.; R. J. Rowlette, M.D. Hygiene.—Sir C. Cameron, C.B., M.D.; C. J. Powell, F.R.C.S., D.P.H. Ophthalmic Surgery.—H. Mooney, F.R.C.S.; F. Odevaine, F.R.C.S. Medicine.—John Marshall Day, M.D., D.P.H.; John O'Donnell, M.B., B.Ch. Surgery (appointed by the General Medical Council).—Sir Lambert Ormsby, M.D., F.R.C.S.; Prof. Conway Dwyer, M.D., F.R.C.S. Midwifery and Gynæcology.—Gibbon Fitzgibbon, M.D.; R. J. Fleming, M.D.

University of Durham.

THE following candidates have passed the first examination for the degree of Bachelor in Medicine, September, 1907:—

1.—Elementary Anatomy and Biology, Chemistry and Physics.—Honours.—First Class.—John Hamilton Barclay, Michael Brennan. Honours—Second Class. —William Hudson. Pass List.—Joseph Jopling Brown, Eleanor Walkinshaw.

2.—Chemistry and Physics.—John Bain Alderson, Ronald Grieg Badenoch, Richard Murray Barrow, Roger Errington, David Farquharson, Sarah Louisa Green, Thomas Albert Hindmarsh, Laurence Heber Warneford Iredale, Frank Hutchinson Kennedy, John Lumb, Benjamin Bell Noble, Charles O'Hagan, Arthur Hyde Wear.

3.—Elementary Anatomy and Biology.—Louis Ernest Seïde Gellé, Harold Llewellyn James, Russell Vyoyan Steele.

The following candidates have pased the second examination for the degree of Bachelor in Medicine:—

Anatomy, Physiology, and Materia Medica (Pass List).—Oscar Frederick Don Airth, Isaac Bainbridge, Helen Grace Clark, Robert Vickers Clayton, Bloomfield George Henry Connolly, John Hare, Samuel Littlewood, George Cuthbert Mura M'Gonigle, John Howard Owen, Madeline Rosa Shearburn, Matilda Ann Sinclair, Eric Hemingway Shaw, Carl Johan Valfrid Swahnberg, Olivia Nyna Walker, Stanley Worthington, James Carruthers Young.

The following candidates have passed the third examination for the degree of Bachelor in Medicine:—

Pathology, Medical Jurisprudence, Public Health, and Elementary Bacteriology.—Honours—Second Class.—Robert Raffle. Pass List.—Hubert Cyril Willoughby Allott, Harriett Amelia Apps, Alexander Hay Bower, John George Campbell, B.A., Leslie Wilson Evans, Patrick Albert Galpin, Francis Frederick Hare, Edward Pierce Hughes, John Pritt Jackson, Annie Viccars Mack, Charles James Neilan, Ruth Nicholson, Charles Elias Reindorf, Theodore W. Stallybrass, Harold Widdrington Sykes, Dorothea Mary Tudor.

NOTICES TO CORRESPONDENTS, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

THE INVENTION OF SPECTACLES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent on this subject in the last issue (September 25th) is in error in supposing that the quotation "Now we see through a glass," etc., might be translated "through glasses." The Greek word means a "mirror."

Yours faithfully,

HEYWOOD SMITH.

25 Welbeck Street, Cavendish Square, W.,
September 26th, 1907.

M. O. H.—As with most questions, there are two sides to the health visitor matter. In his last report, the medical officer of health for Hammersmith says: "It is interesting to note that, notwithstanding the fact that the council appointed a lady health visitor, with the object of lessening the infantile mortality, it has actually gone up eleven per 1,000 as compared with London. These facts rather tend to prove that the causes of infantile mortality are, to a very considerable extent, due to social conditions, and are beyond the power of sanitary authorities to prevent. I am not of opinion that any practical good is achieved by the appointment of lady health visitors." We are inclined to think that such an opinion is not that generally held.

SCHOOL HYGIENIST.—The French have a much more thorough procedure for the prevention of infectious diseases through school influence than anything we know of here. In a recent edict from the Minister of Public Instruction to public elementary school authorities, the most stringent precautions are specifically enjoined. For instance, in the case of scarlet fever, not only is the child to be excluded from school, but his books are all to be destroyed, and general disinfection of the school carried out. Similar precautions are enjoined in the case of measles, and all pupils under six may be excluded from school as well. With regard to small-pox, re-vaccination of all teachers and children is required, in addition to all other measures.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 2nd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.; Mr. J. Berry: Clinique. (Surgical.)

THURSDAY, OCTOBER 3rd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wale's General Hospital, Tottenham, N.).—4 p.m.: Opening Lecture:—Dr. W. H. White: The Various Conditions causing Enlargement of the Liver. (In conjunction with the North-East London Clinical Society.)

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: The Present Position of Dermatology.

FRIDAY, OCTOBER 4th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. A. Lawson: Clinique. (Eye.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. W. Edmunds). Clinique:—Ophthalmological (Mr. Brooks). 3 p.m.: Clinique: Medical In-patient (Dr. M. Leslie).

Appointments.

DAY, W. F. L., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.Lond., Medical Officer and Public Vaccinator for the Parndon, Nazeing, and Roydon Districts of the Epping Union.

EVANS, R. E., M.D., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Newcastleton District of the county of Roxburgh.

HILTON, ALBERT, L.S.A., Medical Officer of Health to the Hurst District Council, Ashton-under-Lyne.

KING, D. BARTY, M.D., M.R.C.P.Edin., Examiner in Medicine and Clinical Medicine at the University of St. Andrews.

MARCH, GEOFFREY COLLEY, L.R.C.P.Lond., M.R.C.S., District Medical Officer by the Dorchester (Dorset) Board of Guardians.

RIGGALL, ROBERT MARMADUKE, L.R.C.P., Third Assistant Medical Officer to the Devon County Asylum, Exminster.

TURNOR, P.W., L.R.C.P., M.R.C.S.Eng., Certifying Surgeon under the Factory and Workshop Act for the Penkridge District of the county of Stafford.

VAN BUREN, ASA CLAUDE ALI, M.D., B.S.Lond., L.R.C.P., M.R.C.S., Honorary Anæsthetist to the Torbay Hospital, Torquay.

Vacancies.

Riccartsbar Asylum, Paisley.—Resident Medical Officer. Salary, £120 per annum, with board and apartments. Applications to J. M. Campbell, Clerk, Parish Council Buildings, Paisley.

Manchester, University of.—Senior Demonstrator in Physiology. Salary, £150 per annum. Applications to the Registrar.

Manchester Royal Infirmary.—Resident Surgical Officer. Salary, £150 per annum, with board and residence. Applications to Walter G. Carnt, General Superintendent and Secretary, Manchester Royal Infirmary.

Jersey Dispensary.—Resident Medical Officer. Salary, £120 per annum, with furnished quarters and attendance. Applications to Secretary.

Bradford Poor-Law Union.—Resident Assistant Medical Officer. Salary, £100 per annum, with rations, apartments, and washing. Applications to George M. Crowther, Clerk to the Guardians, Union Offices, 22, Manor Row, Bradford.

Brompton Hospital Sanatorium.—Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to the Secretary, Brompton Hospital, London.

Worcester County and City Asylum.—Third Assistant Medical Officer. Salary, £140 per annum, and all found. Applications to Superintendent, Powick, Worcester.

Three Counties (Gloucester, Somerset, and Wilts) Sanatorium for Consumptives, Winsley, near Bath.—Resident Medical Officer. Salary, £200 per annum. Applications to the Secretary.

Provincial Hospital, Port Elizabeth.—Assistant House Surgeon. Salary, £225 per annum, with board and residence. Applications to H. Chaplin and Co., 9 Fenchurch Street, London, E.C.

Hull City and County Lunatic Asylum.—Second Assistant Medical Officer. Salary, £150 per annum, with board, apartments, washing, and attendance. Applications to the Chairman of the Asylum Committee, care of the Town Clerk, Town Hall, Hull.

Lewes Dispensary and Infirmary and Victoria Hospital.—Resident Medical Officer. Salary, £120 per annum, furnished apartments, board, coal, gas, washing, and attendance. Applications to Secretary.

Births.

DUNN.—On Sept. 23rd, at Murree, Punjaub, India, the wife of Major H. N. Dunn, R.A.M.C., of a son.

HILL.—On Sept. 25th, at Raincliffe, Dorset Road, Bexhill-on-Sea, the wife of Walter de Marchot Hill, M.R.C.S., of a daughter.

Marriages.

COATES—EWER.—On Sept. 24th, at the Cathedral, Capetown, South Africa, John Coates, F.R.C.S., second son of Edward Coates, of Fulham, London, and Heacham, Norfolk, to Winifred Julia, only daughter of William Thomas Ewer, of Prince's Avenue, Muswell Hill, London.

CUNNINGHAM—WINZER.—On Sept. 27th, at St. John's Church, Westminster, Robert Allan Cunningham, Captain R.A.M.C., second son of R. A. Cunningham, Esq., of Ballybofey, Co. Donegal, to Hope Caroline, youngest daughter of the late J. E. Winzer, Esq., of Hamburg.

DENNIS—RUCK.—On Sept. 25th, at St. Ambrose Church, Bournemouth, Albert Lewis, youngest son of the late Rev. G. M. Dennis, of West Meath, Ireland, to Constance Anne, youngest daughter of the late David Ruck, Esq., M.R.C.S., of Cirencester, Glos.

SEARS—DEW.—On Sept. 28th, at Sydenham Baptist Church, Forest Hill, Charles Newton Sears, M.D., B.S.Lond., M.R.C.S., L.R.C.P., of "Point View," Burnt Ash Hill, Lee, second son of J. Tresidder Sears, Esq., J.P., of Lee, to Annie Florence, the youngest daughter of Charles Dew, Esq., of Forest Hill, London.

Deaths.

JENKINS.—On Sept. 26th, at Colomendy, Ruthin, Josiah Roberts Jenkins, M.D., J.P., in his 81st year.

MEAKIN.—On Sept. 21st, at Nordrach-upon-Mendip, Captain Harold Budgett Meakin, M.D. (Indian Medical Service), aged 37.

STEWART.—On Sept. 27th, Professor Charles Stewart, LL.D., F.R.S., of 38 Lincoln's Inn Fields, Conservator of the Museum of the Royal College of Surgeons of England, aged 67.

WHITE.—On Sept. 2nd, at Hampstead, Major R. W. Persse White, Welsh Regiment, son of the late Robert Persse White, F.R.C.S.I., Dublin.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, OCT. 9, 1907. No. 15

NOTES AND COMMENTS.

Radium for Everything.

THE quack dealers have not hitherto displayed their wonted enterprise in the exploitation of radium as a cure. Considering how electricity and other kindred discoveries have in the past enriched unscrupulous scoundrels who advertised them as cure-alls, and considering also how much more activity there is in the quack world now-a-days, one cannot help wondering whether the enormous price of radium or whether its feeble therapeutic power has been the drawback. As to the price, that need not, on the electric-belt theory, be a consideration at all, for it would not matter whether radium was present or not so long as the advertisements and the testimonial writers said that it was; and as to therapeutic powers the mere fact that doctors had found it of little service would have been the best card a quack-merchant could play to show the unique character of his "discovery." Nevertheless, we have waited in vain. Last week, however, "The Radite Company" ventured into the field and issued a leaflet describing the virtues of their "radite powder," composed mainly of pitchblende and radite, and containing radium. This wonderful powder brings radium into the therapeutic field of the million, and it should be purchased, say the company, by all persons suffering from pain of any kind, all persons suffering from eczema, psoriasis, acne, and other skin diseases, and persons whose hair is growing thin, and so on.

"Freckles and Other Morbid Growths."

THE powder is to be applied in various ways, either on a pad, or as "radite water," or as a "radium disc," which latter will remove warts, corns, moles, birthmarks, freckles, and other morbid growths (*sic*). Malign surface tumours, rodent ulcers, cancer of the skin, and sores in general, may be greatly ameliorated, and in many cases cured by the application of a radium disc. Such a disc is supplied in leather cases for 7s. 6d., whilst "radite powder" costs 5s. per ounce. Now, as radium bromide itself costs £453,592 per ounce, according to the statement of the company, it would make a pretty calculation to ascertain how much radium is contained in radite powder, but perhaps this poverty in the element should really be regarded as the safeguard of this preparation, in that there is not much likelihood of radium-burns. In order that "radite" may become better known a competition on the lines of the present Limerick craze is being organised, and whether the competition or the remedy is to prove the more popular remains to be seen. Still, now the ice is broken we shall probably soon have as many quack advertisements of radium preparations as there lately were of electric belts and batteries, and all of about equal therapeutic efficacy.

Australia and Quack Medicines.

WITH regard to quack medicines, last Christmas the Government of Australia appointed a Royal Commissioner, not a medical man, to inquire into the question of quack medicines in the Commonwealth, and to recommend what steps should be taken with regard to them. This gentlemen, Mr. Beale, has recently issued his report, which is a very voluminous one, and the conclusions he comes to are most far-reaching and important. He recommends that letters-patent should be issued for approved and novel formulæ for the prevention and cure of human ailments, and though this suggestion would sweep away all present patent medicines, not one of which is novel or original in any degree, we fear it would tend to act as a commercial incentive to real discoverers who now give their work freely to the world. Still, such a rule would do no harm if it were more honoured in the breach than in the observance, except in so far as concerns the denying of patents to remedies that are not novel, and such refusal in itself would constitute a valuable reform.

And Their Cure.

BUT Mr. Beale's further recommendations are those which lie at the root of all proper patent medicine regulation. He suggests that every patent medicine when retailed shall bear its formula of preparation on a label; that no advertisement shall be allowed on the article itself or its covering; that no advertisement of any proprietary or secret cure shall be allowed to be published; and that transmission of advertising matter concerning such medicines through the post shall be forbidden. If we make the slight reservation that genuine new preparations prepared by respectable firms should of course be made known to medical men through the post and by advertisement, we can most cordially endorse Mr. Beale's conclusions, which would finally dispose of the most glaring public fraud of the day. It is a humiliating but none the less a well-deserved reproach that this Colonial Commissioner should point to the Mother Country as demanding "an eighth share in the full retail price of every, even the most pernicious, proprietary specific under quasi-medical pretence." We recently drew attention to the interesting fact that the Cape Legislature recognised the undesirable character of certain cancer "remedies," and forbade their sale; New Zealand is making a big struggle against the newspaper interest to rid herself of the plague; and Australia has its way now mapped out for it, if it will move. The "Old Country" has not even turned in its bed.

Temperance Research. WE have been asked to notice the proposals of the Education Committee of the National Temperance League with regard to some operations they hope to take in hand. This committee is asking for funds to promote scientific research into the nature and effects of alcohol, to translate scientific treaties on the same subject from Continental language into English, to distribute literature dealing with the effect of alcohol on the human organism to leaders of thought, to hold education conferences, to promote the teaching of hygiene and temperance in schools, and to publish fresh evidence as obtained regarding the deleterious action of alcohol on the tissues. These are highly commendable objects, and the committee is strongly manned with names which command respect, but we cannot help thinking that the League, being a militant one, would do well to leave research alone. Scientific inquiries are best conducted in an absolutely impartial atmosphere; indeed, we might say, can only be so conducted. The temptation of making facts square with predilections is so great to our frail human minds that any research work conducted by the League would necessarily fall under the suspicion of being biassed, and surely there must be plenty of educative work to be done on facts already known.

LEADING ARTICLE.

THE SHEFFIELD UNION INFIRMARY DEADLOCK.

THE touch of sensationalism given by the lay Press in their headlines, "Doctors on Strike," in connection with the recent occurrences at the Sheffield Union Infirmary, was in no way justified. There has been no "strike." The rules and regulations under which the staff worked did not conduce to comfort and pleasure on the part of the resident staff; dissatisfied with their position, they resigned, as they had a perfect right to do, and there had been several resignations during the preceding year. The Guardians wished to have a visiting staff, consisting of a physician and a surgeon, whose position was to be more or less honorary, but who were to receive an honorarium or salary for their services, fixed respectively at £141 15s. and £115 10s. a year. They were fortunate in securing the services of two of the leading men in the town to take the positions, chiefly because of the increased clinical experience attached thereto. No one could say that the remuneration erred on the side of full market value, when it is remembered that they were responsible for the treatment of all the patients in a hospital of 500 beds, and that they were bound to visit three times a week, the rate of pay being less than £1 a visit. To assist them, three resident medical officers were appointed, their positions being on a par with that of house surgeons in an ordinary hospital. The main source of difficulty arose in trying to meet the requirements of the Local Government Board, as to having a responsible officer to discharge the duties of "Medical Superintendent." Neither of the visiting staff accepted that position. It was sought to place the burden upon the senior resident medical officer. Whilst asking him to take on these duties, the Guardians refused to define the limitations of his duties and responsibilities. The resignations which have taken place from time to time arose from the friction to which this unsatisfactory condition of affairs not unnaturally gave rise. The residents say that the Guardians treated them with a want of proper consideration when they brought matters to their notice; the Guardians seem to have thought that all that these young men had to do was to receive any orders that were given to them, and carry them out without any reference to what their feelings in the matter might be. It is hardly surprising that this scheme of the Guardians was found in practice not to work, however estimable it might have been in theory. The absence of a well-paid, responsible officer at the head of affairs, whose duty would be to see that the requirements of the Local Government Board were properly carried out, who, on the one hand, would have the affairs of the hospital, as to staff and management, well under control, and on the other, would be responsible to the Board for the administration of the institution, is the real cause of the recent breakdown of the Guardians' scheme, and of the resignations which have taken place. The cost of the recent scheme was £557 5s.; when one remembers that there are 500 beds in the hospital, no one can say that the Guardians rate the services of their medical men too highly. The old order having passed away, the new scheme of the Guardians is as follows: There are three resident men to be appointed; a superintendent medical officer, who is to be between thirty and forty years of age, and who is to have a salary of £300 a year, with board and residence, and two assistant medical officers, with salaries of £100 and £80 respectively, the total cost to be £480. The change effects a saving of some £75 5s. Three men are to do the work of the five that held the appointment before. The writer of "Current Topics" in the *Sheffield Daily Telegraph* says, "We should like to know how it comes about that if three doctors are sufficient now, five were employed heretofore. In other words, can three men do five men's work? The saving, of course, is fatuous; the figure is too small to worry about. It is only efficiency that matters in such a case." Of course, if men are to be fouud who are satisfied with such remuneration for so responsible a post as that of medical superintendent, having reached the age of between 30 and 40, there is no more to be said; the Guardians would be foolish to pay more. Possibly the class of cases admitted to such infirmaries may not be such as to require a high order of medical knowledge or skill, and there are men whose ambition in life would be quite satisfied, at such an age, with the benefits and emoluments of such a post. They are not likely to go much farther in the race of life. We can but wait and see how matters work out.

The Guardians tried to throw the responsibilities of the resignations upon the Sheffield District of the B.M.A. They said it was the result of action taken by the District. This, of course, the local secretary was able at once to repudiate. The District had taken no action in the matter until after the resignation of the three residents. They then considered matters, and came to the conclusion that it was not their concern; but, contrary to the wishes of several men in the District, they passed a resolution, that "they considered, under the circumstances, that the posts at the Infirmary were untenable." Those who objected to their taking any notice of the affair at all did so on the grounds that, as they were not going to meet a delegation from the Board of Guardians to discuss matters, or mix themselves up in the affair, it would be wiser to say nothing, as any action of theirs would only be taken on a one-sided statement of what had taken place.

THIRD REPORT OF THE ROYAL COMMISSION ON VIVISECTION.

The Royal Commission on Vivisection has just issued the third volume of the minutes of evidence taken before it, and without prejudice it may be said to be even more damning to the "cause" than its predecessors, little encouraging as they were. An interesting witness was Lord Justice Moulton, who, as an eminent lawyer and a scientific man having had no personal contact with experiments on animals, may be regarded as what he was actually called by Lord Selby "a highly qualified outsider." Lord Justice Moulton, both from the point of view of the increase of knowledge and from that of ethics, was in favour of the practice of experiments on animals under due regulation, holding that one is justified in the present state of affairs in inflicting a lesser evil when there is a reasonable prospect of avoiding a very much greater one. But from the logical moderation of Lord Justice Moulton we turn to the utterances of the Hon. Stephen Coleridge, who was under examination for three days, and who managed in that time to execute a series of verbal gymnastics which may well puzzle both his satellites and the objects of his venom. Since the days of the Bayliss libel trial, when Mr. Coleridge was convicted by twelve of his fellow countrymen of the sin of "talking through his hat," there have at times been signs almost of grace in that eminent protagonist, but we confess that we raised our eyebrows when we read that Mr. Coleridge, in his evidence, said that he directed himself against the infliction of suffering, but did not object to the utilisation of animals for scientific purposes, provided it was painlessly conducted. We must not too hastily assume that Mr. Coleridge is now a moderate vivisectionist, as these words would seem to imply, for it seems he considers anæsthesia, when testified to by expert physiologists, as not sufficient for his purposes. Apparently he considers scientific men as ready to state any untruth to cover their misdeeds. Experimenters, he said, would deny a breach of the Experiments on Animals Act, 1876, just as he himself would deny a breach of the Motor Car Act. "I drive a motor car, and when I go beyond the speed limit and a policeman asks me, I say, 'No, I am not going beyond the speed limit.' Nothing would keep me from going beyond the speed limit except the presence of a policeman in the car." On being asked whether he would expect his word to be disbelieved, Mr. Coleridge replied, "No, I do not say so." If anyone can make rhyme, reason, sense, or consistency out of Mr. Coleridge's efforts before the Commissioners, they will have accomplished a task beyond the powers of plain men who are accustomed to use the word "Yea" and "Nay" in their exact and literal signification. Miss Lind-af-Hageby, of "Shambles of Science" fame, gave evidence to the effect that she did not believe that vivisection experiments were generally carried on under deep surgical anæsthesia—and against a woman's belief it would be absurd to argue—and also that she objected to vivisection on the whole principle of exploiting the lower animals for our supposed service and use. The latter is a comprehensible position, but if adhered to by a society which eats beef and eggs, drinks cows' milk, drives in 'buses (not motor), and wears boots, it would entail considerable change in custom. Beyond these witnesses there were some minor anti-vivisection lights, and a number of scientific and medical men, but their evidence pales into insignificance before that tendered by Mr. Coleridge and Miss Hageby.

CURRENT TOPICS.

The No Man's Ground of the Milkman.

The community has much to endure at the hands of the milkman. Not least of all is the crashing of his pails and the rattling of his springless carts. When the small things of social reform come to be handled by county councils we may hope to have springs fixed to his—and for that matter to all tradesmen's—barrows, and buffers attached to milk cans, so as to lessen their brazen and altogether unnecessary clatter. So much for milkman's form, now for his material. On the whole there can be little reasonable doubt that an immense amount of diluted milk is daily palmed off upon a long-suffering public. In spite of laws and by-laws galore the merry milkman, with a mild twinkle in his meditative eye, goes his way from morn to eve placidly retailing water at the price of pure cow's milk. Truth to say, legislation, whether of Parliament or of local council chamber, has left him on a sort of Tom Tiddler's ground, whence he may survey with indifference the heathen raging of the sanitary authorities. If he is haled into court all he has to do is to produce a warranty of purity from the farmer who has sold him the milk, and to swear he has retailed it in the same condition. He promptly leaves the court without a stain upon his character. The farmer never attends, and the difficulties in the way of fixing the offence upon the farmer are hopeless. The way out of the wood—as recently pointed out by the correspondent of a London daily—is to summons both milk dealer and farmer together, and let them fight it out in court. Then there would be some chance of the honest ratepayer coming by his own.

The Veterinary College and Unqualified Practice.

The College of Veterinary Surgeons, fortunately for its diplomates, seems prepared to protect their rights in a way that might well be taken to heart by our own Medical Colleges. At Feltham Petty Sessions the Veterinary College prosecuted an Ashford resident, named Wilson, for stating that he was specially qualified to practice a branch of veterinary surgery by publishing the description "canine and feline medical expert." The owner of a St. Bernard puppy stated that he took the dog to defendant, who produced a stethoscope, and having examined the dog all over, said it suffered from kidney disease. £1 was paid, and the dog left with defendant, who wrote saying the animal was suffering from rickets, and later, again, from worms. The dog was with him from April 15th to June 13th, and 12s. 6d. was paid weekly. The defendant stated he had practised for seven years in Ashford as a canine and feline medical expert. He had never claimed to belong to the Royal College of Veterinary Surgeons. Had he omitted the word medical from his description dogs and cats would have been brought to him for an opinion as to their value only. The Bench convicted defendant, and imposed a fine of 20s., including costs. It would be of interest to know in how many instances, say, during the past twenty years, prosecutions for illegal practice have been undertaken by the Royal Colleges of Surgeons of the United Kingdom. Their attitude in this respect, indeed, to some extent, warrants the inference that having taken the qualification fees of their diplomate their interest in his welfare ceases. In any case it is abundantly clear that our own Royal Colleges have neglected the duty that should be encumbent upon them of protecting their fellows, members and licentiates against the inroads of unqualified practice. It is no excuse for these ancient and wealthy corporations to plead that their statutory powers are insufficient. A little well-directed importunity would doubtless long ago have secured the necessary legislation. What the much-abused general practitioner wants is a one portal qualification with stringent laws against unqualified practice.

Deficient Mortuary Accommodation.

The inadequate mortuary accommodation in many parts of the United Kingdom, both rural and urban, has been the cause of public protest time out of mind. In certain districts, indeed, it has drifted into the position of a recurrent scandal. One of the worst features of the lack of proper accommodation is that dead bodies are often taken to public houses, where they lie in an outhouse until the inquest is held in the convenient taproom adjoining. As a rule, after a few strong protests, the matter is allowed to drop, and the same dismal tragedy is enacted again and again. Were all coroners as strong and determined as Dr. Drage, the Coroner at New Barnet, it is likely that before long the general public mortuary accommodation of the country would be considerably increased. At a recent inquest, being informed that a body had been placed in a stable infested with rats, he declared it was the duty of the overseer to provide a place for the reception of bodies. He then directed his officer, pending the provision of proper accommodation, to take bodies to the drawing-room of the nearest overseer. This order naturally brought the overseer up in arms. First, he provided temporary accommodation, and then cancelled his order, whereupon the Coroner's officer declared he would take the next body to the overseer's house, where, if refused admission, he would leave it on the doorstep. We understand that Scotland Yard has been summoned to the spot. Meanwhile, further developments may be awaited with interest.

Poisons in Sweetmeats.

It is, of course, a law of the land that certain poisonous drugs may not be sold to the public, except by registered chemists. The reasons for such limitation are obvious, and it is of importance to the safety of the public that the law in this matter should be strictly obeyed. By many methods, however, it is systematically evaded, and to one of these Sir James Crichton-Browne has drawn attention in a recent address. He has had analyses made of lozenges of various kinds commonly sold by grocers, and it has been found that such poisonous drugs as chloroform and chlorodyne are constituents of many of them. These noxious bodies are commonly combined with such innocent drugs as liquorice and linseed, and the compound is sold ostensibly to relieve cough. Sir James has evidence, however, that the lozenges are widely consumed as mere dainties, and there is little doubt that they are used for their analgesic properties. Analysis of certain lozenges sold in Liverpool showed from 2 to 3 per cent. of chloroform present. These lozenges were on sale in small confectionery shops, and could be bought without difficulty in any quantity. In other cases, lozenges containing chlorodyne were obtained with equal ease. There would seem to be no practical difficulty in the way of checking this noxious trade, now that public attention has been drawn to it. It is comforting to reflect, however, that so-called "chlorodyne" lozenges often contain no vestige whatever of the drug in question. A cheap substitute is used by proprietary nostrum vendors, in accordance with the universal rule among that fraternity, which hates expensive ingredients as the Devil is reputed to hate Holy Water.

The Police and the Medical Profession.

Nowadays a great deal is heard about the high-handedness of police methods, and there seems to be in many cases a certain amount of justification for the charge. While making full allowance for the difficulties of a position which, on the whole, is filled with credit and honesty, it is nevertheless necessary to remind the force at times that they are the servants and not the masters of the public. The recent absolutely indefensible action of the police in their prosecution of Dr. Bagley, of Manchester, for obstructing and assaulting the police in the execution of their duty, affords an extraordinary picture of what an arrogant police official can do in defence of his own illegal act. Dr. Bagley was called in to an old man who had attempted suicide, and whose throat he stitched up. He remonstrated when the police wished to remove the old man to Ancoats Hospital, and joined the sons in an ineffectual resistance to that removal. The magistrates held that the police had no right to enter the house and remove the man without a warrant, and they dismissed the case against Dr. Bagley. The latter, however, incurred costs to the extent of £30, which the Watch Committee refused to pay. The local medical profession have sent a strongly worded remonstrance to the Manchester authorities. It certainly seems hard that it should cost a private citizen £30 to teach the police an elementary lesson in their rights as regards apprehending an Englishman in his own house. After this occurrence possibly the Watch Committee will consider the advisability of classes of instruction and test examinations for its police constables.

The Midwives' Act.

The Midwives' Act has now been before the public and the medical profession long enough to justify comment upon its results. On the whole it may be said that while, on the one hand, there is no tangible evidence that the maternity of the kingdom is now being conducted under more favourable conditions, there is, on the other hand, considerable reason to believe that the forebodings of the medical profession are being more or less fulfilled. The general practitioner has to some extent ceased to devote himself to the serious practice of midwifery, a branch of work which was formerly one of the mainstays of the professional income. Moreover, it should be remembered that all knowledge in midwifery, on which the midwife depends for guidance, has been founded on the accumulated experience of many centuries of medical practice. The exercise of this most arduous craft has been handed over to a partially-educated class of women, the most crucial part of whose technical education consists in acquiring an inkling of the complications that need the highest of all possible professional endowments by way of skill, knowledge, and power to act. Has the average mother gained by the institution of that hybrid, the licensed midwife? We think not, for while a cold water douche has been thrown upon her old and faithful friend, the family doctor, she has been provided with a substitute who is admittedly unequal to face the unexpected, which in midwifery is often the difference between life and death. Now the midwife shares with the medical man the honorary privilege of notifying births, a logical extension of her rights that must fill with pleasure her drawing-room friends.

The Strait Jacket in the Workhouse.

A recent inquest held by Mr. Walter Schroeder on a patient who died at the Hampstead Workhouse Infirmary reveals a state of affairs that appears to demand full official inquiry. It seems that a man was sent to the institution named at 2 p.m. on Wednesday last, and died at 7.35 next morning, without having been seen by a medical man. About 11 o'clock on the night of his admission he became noisy, and the lunatic attendant, on his own authority, placed him in a strait jacket; he collapsed at 6.40 a.m. The medical attendant was telephoned for at 7 a.m, but the patient died before his arrival. This appears to be one of the recurrent workhouse scandals of a familiar type in which a delirious patient, a non-resident medical officer, a strait jacket and an overworked single-handed attendant play the chief part. It is to be hoped the Local Government Board will, in this instance, intervene so effectually that the possibility of a repetition of anything of the kind may be rendered impossible. At certain London institutions we believe something of the same kind has been going on for year after year. Where are the Medical Inspectors of the Local Government Board? Surely they were familiar with the shortcomings of the Hampstead Workhouse Infirmary organisation.

The Workmen's Compensation Act Referees as Witnesses.

Now that the medical referees have begun work in the Courts under the Workmen's Compensation Act it is desirable to consider the circumstances under which their office is discharged. Not long ago in the Liverpool County Court a point of vital importance was raised by counsel. It appeared that the medical referee had agreed to give evidence on behalf of defendant. His position was commented upon by the appellants in the severest terms. Quite reasonably, as it will appear to most plain men, they held that the referee, having accepted a judicial position, was by implication cut off from acting as a partisan expert. Counsel submitted that to adopt the latter function was indecent, and contrary to public policy, and that it was a difficulty provided against in the Act. The other side maintained that the referee was not bound to the county court in any official capacity, and his official appointment began only when he was appointed to any particular case. The judge held the same view, and ruled it was competent for the referee to appear as witness; but in such a case he would be invalidated from acting subsequently as referee to the Court. As a matter of good taste it would seem desirable that medical referees, except under most exceptional circumstances, should refrain from appearing as expert witnesses in compensation claims.

PERSONAL.

Dr. John Freeman, of University College, Oxford, has been elected to the Radcliffe Travelling Fellowship for this year.

We regret to record the death of Dr. Seneca D. Powell, Professor of Surgery in the New York Post-Graduate School and Hospital.

Sir Felix Semon will give a lecture to the Manchester Medical Society on October 16th on "English and German Medical Education—A Parallel."

Dr. George Reid will read a paper to the Incorporated Society of Medical Officers of Health on October 11th, at 5 p.m., on "The Planning of Schools."

Dr. Montague Murray will open the course of post-graduate demonstrations at Charing Cross Hospital with a lecture on "Medicine," to-morrow (Thursday).

Dr. J. Kingston Fowler, President of the Medical Society, will give his introductory lecture on October 14th at the inauguration of the 135th Session of the Society.

The Watch Committee of the Bradford Corporation have chosen for the chief police surgeonship William Wrangham, M.D. The appointment is for twelve months.

Canon Arnott, who was once Lecturer in Pathology at St. Thomas's Hospital, is to preach before the Society of Apothecaries at St. Andrews-by-the-Wardrobe.

Sir Lauder Brunton, M.D., LL.D., will deliver the inaugural address of the winter session at the London School of Tropical Medicine, Connaught Road, Albert Dock, on Monday, October 21st.

Sir Thomas Barlow, President of the Section, will give the opening address of the Clinical Section of the Royal Society of Medicine at 20, Hanover Square, on Friday, October 11th, at 8.30 p.m

Dr. James Collier opened the winter session of the National Hospital for Paralysed and Epileptic, Queen Square, London, yesterday (Tuesday) with a lecture on "Local Lesions of the Spinal Cord."

Professor Osler, F.R.S., will give the opening address at the University College Medical Society on October 16th on "The Influence of Medical Society on the Education of the Medical Student." Sir Thomas Barlow will be in the chair.

A CLINICAL LECTURE

ON

THE SPHYGMOMANOMETER IN MEDICINE.

By ROBERT SAUNDBY, M.D.Edin., Hon. LL.D., Hon. M.Sc., F.R.C.P.Lond.,

Professor of Medicine in the University, and Senior Physician to the General Hospital, Birmingham.

THE old authors described the pulse as large or small, hard or soft, quick or slow, and so late as the reign of Charles II. Sir John Floyer, of Lichfield, was the first who began to count it by its number of beats per minute, for which purpose he invented a special watch. From the time of Sir John Floyer the old terms "quick" and "slow" have been replaced by numbers and recorded in figures, so that in this respect at least every medical practitioner, thanks to him, thinks accurately and precisely. But for nearly two hundred years the other features of the pulse remained undetermined. In the sixth decade of the last century the sphygmograph of Marey placed in the hands of the clinician an instrument which enabled him to record upon paper the oscillations of the pulse, and to compare the curve of the hard pulse of Bright's disease with that of the soft pulse of pneumonia, and to study the changes produced by alterations of the valves of the heart the stethoscopic signs of which had recently been brought to perfection. The sphygmograph of Marey, excellent instrument though it was in the hands of patient and skilful observers, has been superseded by the simpler and more easily applied form introduced by Dudgeon, which has remained practically unmodified for twenty years—a striking test to the sound principles of its construction. A careful study of pulse tracings and a comparison of their curves shows that the amount of information to be derived from them has limits, and that contrary to what had been thought by the earlier observers it is impossible to rely upon them for estimating the blood pressure. The blunt-headed tracing often met with in high pressure pulses is due, not directly to the pressure, but to the prolongation of the systolic wave, which may proceed from other causes, and the pressure-gauge attached to the sphygmograph is conditioned by too many factors, such as the thickness of the tissues surrounding the radial artery, the rigidity of the instrument, and the tolerance of the patient, for the results to be relied upon. Various sphygmometers have been invented to supply this defect, such as the capsule of Prof. von Basch, which was constructed on the principle of an aneroid barometer, or Oliver's pulsometer, in which the force of the circulation is measured by the compression of a spiral spring. My experience of these instruments is that their readings are too variable in the hands of different observers to be of value. It was, therefore, a distinct advance when Barnard and Hill introduced an instrument consisting of a mercurial manometer, which measures in millimetres the pressure required to obliterate the pulse at the wrist. At the present time the sphygmomanometer of Riva-Rocci, as modified by Dr. C. J. Martin, is probably the best instrument available for clinical work; by it, in the course of two or three minutes, the pressure in the radial artery can be read off in millimetres of mercury. The pulse should be counted and recorded at the same time and observations which are intended to be compared should be made in the same position, either sitting or lying down, and the manometer should stand at the same level as the patient's heart. I have been using Dr. Martin's instrument daily for the last year, and have accumulated sufficient data to enable me to say something of the practical help it may give us.

In the course of this lecture it is not my intention to discuss the pulse pressure in all diseases, even if I had sufficient material from which to draw conclusions, but I propose to direct attention to some general facts and to the results of observations in certain forms of disease.

THE NORMAL PRESSURE.

From my own observations with this instrument the normal arterial pressure in healthy young adults has usually been between 125 and 140 mm. Hg.

AGE.

It is generally asserted that advancing age is in itself a cause of raised blood pressure, and so far as my observation goes this seems to be true, that is to say, people over 70, even when in perfectly good health and with no signs of arterio-sclerosis in the shape of thickened radial artery, have a blood pressure of about 170. Healthy middle-aged or elderly persons do not show any rise. Children on the other hand do not necessarily have a low pressure, and often are above the normal without any obvious cause. In fact, if my limited observations are to justify any conclusion it is that in infants and quite young children the blood pressure is more often from 140 and 150 than below, although where there is serious illness it may fall lower than it does in adults, as for instance in a child aged two years and four months, with broncho-pneumonia and fluid in the left side of the chest, the blood pressure was only 70 and pulse 160. Among adults low blood pressure (below 100) is very uncommon even where the patient is very ill. Thus I have recorded a blood pressure of 98 in a boy aged 14 with malignant endocarditis, and 95 in a boy of 13 with pericarditis; a girl of 14, suffering from phthisis, had a pulse of 120 and a blood pressure of 95 to 100. A man aged 34, with malignant endocarditis, had a blood pressure of 125, and a man aged 48, with fatal pericarditis, had a blood pressure of 185! I have seen the blood pressure as low as 95 in a married lady aged 43 with atonic dyspepsia, but it is in my experience quite an exceptional case.

ALCOHOL.

The influence of alcohol on the blood pressure was not quite what I had anticipated. The effect of half an ounce of whisky on a young man aged 28, in good health, is shown in the following table:—

Time.	Blood Pressure.	Pulse.
12.13	150	68
Half an ounce of whisky with soda water.		
12.25	135	64
12.37	170	60
12.52	130	56

In the case of a man with general dropsy from subacute nephritis supervening upon chronic Bright's disease, who had been ill two months, but had previously been very temperate in regard to alcohol and tobacco:—

Time.	Blood Pressure.	Pulse.
5.35	205	72
Half an ounce of whisky with soda water.		
5.55	230	—
8.25	225	—

A man, aged 58, had been admitted for epistaxis; he had some albuminuria and a hypertrophied heart; pulse, 78; blood pressure, 230. On low diet the pressure dropped to 135, and then rose to 143; after half an ounce of whisky it rose in six minutes to 150, and fell gradually to 135, at which it remained for the rest of the evening, and was at that figure at 10.15 the following morning.

Another man, aged 39, who had been a heavy drinker and smoker, was admitted with mitral disease and dropsy. There was a faint haze of albumen; pulse, 100; blood pressure, 160. On June 5th he had half an ounce of alcohol; 15 minutes later the blood pressure had fallen to 150, and 1½ hours later to 145.

A man, aged 43, with aortic and mitral disease, and of alcoholic habits, whose urine contained a trace of albumen, had a pulse of 116; blood pressure, 140; some time after admission his pulse was 60; blood pressure, 145.

Time.	Blood Pressure.	Pulse.
12.7	145	60
Half an ounce of whisky with soda water.		
12.23	170	44
12.33	140	46
1.13	135	45
1.57	150	60

The pressure remained at the last figure late in the evening, and was still the same the following morning.

Lastly, a man, aged 35, suffering from aortic disease, of alcoholic habits, with albuminuria; pulse 80, and blood pressure 140. Some weeks after admission his pulse was 60, blood pressure 165. Half an ounce of whisky with soda water:—

	Blood Pressure.	Pulse.
After 10 mins.	168	54
,, 20 mins.	145	58
,, 35 mins.	145	56

The following morning his pulse was 76, blood pressure 150.

On looking over these figures, it will be seen that, although, as a rule, a slight rise of pressure occurred a few minutes after taking the whisky, the rise was slight, and not more than might have been caused by the absorption of a certain amount of fluid. In the case of the healthy man there was a slight initial fall, followed by a slight rise, and then another fall. In most the initial rise was followed by a fall, and in only one was the pressure permanently raised—viz., in the case of advanced Bright's disease with dropsy.

In all the cases where a record has been kept, the pulse rate and the blood pressure have risen and fallen together.

On the other hand I do not find that chronic alcoholism, where it has not been complicated by Bright's disease, causes permanent high blood pressure; indeed, where the patient's general health is falling off, it may be quite low, as in the case of a patient, aged 56, suffering from chronic alcoholism, with gastritis and enlarged liver. His pulse was 114, and blood pressure 125; another patient, aged 36, with the same condition, pulse 84, blood pressure 125; a third, aged 64, with cirrhosis and ascites, after the ascites had disappeared, pulse 96, blood pressure 145.

Tobacco.

The statement has been frequently made that smoking tobacco raises the blood pressure and consequently embarrasses the action of a weak heart. I do not doubt that there is sufficient clinical experience to warrant us in continuing to give advice to patients who suffer from weak hearts, whether due to valvular disease or not, to smoke little or not at all, but the sphygmomanometer does not show any marked alteration in either pulse or blood pressure, after smoking.

Hesse has undertaken a series of experiments in order to determine whether tobacco exercises any direct influence upon the circulation. The subjects of these experiments were partly medical students and partly patients in hospital. The state of the blood pressure and the frequency of the pulse were noted before, during, and after smoking one, two, or three cigars in succession. In 17 out of 25 cases there was a slight increase of the frequency of the pulse, associated with a rise of arterial pressure, which was sometimes marked; in five the rise of pressure was unaccompanied by increase in the frequency of the pulse, and in three the blood pressure fell slightly, while the pulse frequency rose a little. It was noticeable that the chief increase in blood pressure occurred in subjects whose ages were from 45 to 57 years, while in young people the alteration was much less marked, so that it would appear that when the organism is young it adapts itself more readily to the injurious effects of tobacco. The result was influenced by the presence of certain organic diseases, especially pulmonary emphysema. It is important to observe whether the subject is, or is not, used to smoking tobacco; it would naturally be supposed that the effect would be more marked in the latter case, but it did not appear to be so, although the number of cases in which the point was tested was too small to enable any definite conclusion to be reached. The effect of tobacco on both the blood pressure and the pulse frequently reached its maximum at the end of from twenty to forty minutes when they returned to the normal limits. In three instances, after the experiment, a slight accentuation of the aortic second sound was observed.

The observations that I have been able to make have been few in number, but so far as they go they tend to show that at any rate in the case of habitual smokers the effect of the use of the weed on the blood pressure is slight. The first case was that of a man who is a tolerably heavy smoker and whose blood pressure at 9.34 a.m. was 140; pulse 84; in the course of the day he smoked half an ounce of hand-cut tobacco and two pipes of twist. His pulse and blood pressure were taken at intervals with the following results:—

Time.	Blood Pressure.	Pulse.
10.35	144	82
12.15	140	84
6 p.m.	160	84
Next morning.		
9.40 a.m.	140	84

No doubt this table shows a rise of 20 mm. at 6 p.m., but in this man's case the blood pressure has been frequently even higher; there is no reason to ascribe it to smoking, as he was an habitual smoker and began to smoke in the morning directly after the blood pressure was taken at 9.35, so that any effect due to tobacco should have been observed earlier in the day.

The other man smoked daily a quarter of an ounce of tobacco. His blood pressure was as follows:—

Time.	Blood Pressure.	Pulse.
9.30 a.m.	120	60
10.40	120	72
12.15	100	80
6 p.m.	120	74
Next morning.		
10 a.m.	120	68

In this case there seems to have been a slight acceleration of pulse with lowering of the blood pressure as the result of smoking. These subjects were elderly men; the first was a case of polycythæmia and the second one of chronic diabetes; both men had been for long under observation. The diabetic patient is weak, and is probably suffering from the degeneration of the heart which occurs in advanced cases.

Diabetes.

According to Potain diabetes is a disease accompanied by high arterial tension, his average being 220 in hospital patients, and 260 in private practice, with a minimum of 100 and a maximum of 310!

On the other hand, Vaquez in his report to the Seventh French Congress of Medicine (see *La Semaine Médicale*, 1904, p. 339) insisted on the fact that the tension is normal in many cases.

J. Teissier thought cases with increased tension generally belonged to the class of fat diabetics, while those with low tension were the cachectic type, or those complicated by phthisis.

Ambard (*Semaine Médicale*, 1906, p. 362) said that the cases with high tension were those with albuminuria, although all cases with albuminuria did not show high tension.

Severie (Paris Thesis) has studied 29 cases of diabetes and two of diabetes insipidus; the maximum was 240 and the minimum 90. Those with high tension were either cases of marked Bright's disease or gouty or arterio-sclerotic patients, with or without albuminuria. The tension varied from 190 to 240. Another case was at the same time arterio-sclerotic, albuminuric, and tubercular; the tension was at first 180, and fell rapidly to 120, and death occurred suddenly. Another patient, diabetic for four years, showed some signs of early phthisis at the left apex and had had hæmoptysis, yet his tension was 220. These examples show that pulmonary tuberculosis does not necessarily lower the blood pressure. The majority of diabetics who were neither emaciated, nor albuminuric, nor arterio-sclerotic showed a blood pressure about normal (?) 160, 170, or 180; in one case the tension was as high as 190 in a man of 50 (he was passing 153 grms. of sugar daily), and as high as 240 in another patient, aged 54, with neither cardiac nor pulmonary trouble nor albuminuria.

Those with low tension were chiefly tubercular. Ten tubercular diabetics had tensions ranging from 100 to 150, the average being 129. But cases showing marked failure of nutrition, with rapid cachexia, even when free from tubercle, occasionally showed low tension. For example, a man of 55, whose diabetes was only of 14 months' duration, had lost 50 lbs. in weight, and, in spite of diet, passed 204 grms. of sugar in 24 hours; his tension was only 120 to 130; another man of 33, passing 8 to 10 litres daily, with 600 to 900 grms. of sugar, in spite of diet, had a tension at first of 200 to 270, falling rapidly while the cachexia made progress, and was only 90 when he died. Cases of tubercular diabetes show a rapid fall of tension a few days before death, and it may be said that a marked low tension is always a bad prognostic in diabetics, whether the patient is or is not tubercular. On the other hand, high tension is not a specially grave indication, unless it rises to about 250, when it should give cause to fear various complications, especially cerebral hæmorrhage; but the fat type of diabetic may often present a tension of 190 to 210 without involving any immediate aggravation of the diabetes. Such are the conclusions arrived at by Dr. Severie.

I have studied the blood pressure in 25 cases of diabetes, of which 7 were albuminuric. The maximum blood pressure was 180, and the minimum 110; the maximum of 180 was reached, but not exceeded, in both albuminuric and non-albuminuric series. The lowest pressure amongst the albuminuric cases was 120, but this patient was tubercular, and it occurred soon before his death. Of the non-albuminuric cases the lowest was 110; this was also a few weeks before the death of the patient, who was not tubercular, but old (67), weakened and worn out by the disease. The average pressure amongst the albuminuric cases was 143, and the non-albuminuric cases 139, but the albuminuric cases were on the average considerably older (50) than the non-albuminuric cases (38). The only tubercular case was among the albuminuric patients, and his low blood pressure had some effect in reducing the average. One death occurred in each series, and each fatal case gave the lowest recorded pressure. The conclusion to be drawn from these cases is that a low pressure (below 130) is of bad prognosis, and is only met with in cases which have not long to live, but a single observation must not be relied upon, as a neglected patient may be run down and weak, and his blood pressure be very low, but after treatment he may recover, as in the case of a man I have at present in hospital; yet such a drop indicates that the case is grave and the condition serious, as it undoubtedly was here, for it was accompanied by loss of weight and di-aceturia.

Heart Disease.

Nothing is more paradoxical than the figures given by the sphygmomanometer in cases of heart disease, for even when uncompensated and requiring the patient to be confined to bed, the pulse tension sometimes is above normal, often normal, less often slightly reduced, and rarely or never lower than 110 to 115, except in children. In aortic regurgitation pressure may be quite high (210 to 220), and it was never less than 125. In some cases of mitral disease it was as low as 110 and 115, but was usually about 140, and occasionally as high as 180. Apparently the heart keeps the circulation to the normal level so long as it continues to beat, in spite of valvular disease or even grave lesions of the myocardium. A case of angina pectoris in a man aged 50 showed a blood pressure of 210 and a pulse of 60; there was no albumen in his urine, but he had used alcohol and tobacco. In leucocythæmia, simple anæmia, and in Hodgkin's disease, the blood pressure was low, but never much below normal limits, the minimum being 110 in a case of slight anæmia, with marked debility.

Bright's Disease.

As might be expected, it is in Bright's disease that the sphygmomanometer gives most marked departures from the normal, but it is only in chronic nephritis that high readings are constant. In acute and subacute cases the blood pressure is often normal, and I think it might be said that in cases that look like acute or sub-acute nephritis, where the blood pressure is over 160 or 170, the probability is that the case is one of chronic nephritis, upon which an acute or subacute attack has supervened. On the other hand, cases of nephritis where the blood pressure is not high are those not complicated by cardio-vascular disturbances. A high blood pressure may fall before death, as it did in a case of cardiac hypertrophy complicated by pericarditis, where it fell from 190 to 175, and subsequently to 125. In chronic Bright's disease the blood pressure is over 160 or 170, and may reach or exceed 300, which is the limit of the scale on the instrument.

Uric Acid.

There is an impression generally entertained that patients whose urine deposits uric acid suffer from high blood pressure, but so far as I have been able to observe such cases, I do not think there is any necessary connection. A boy, aged 9, in the hospital under my care, passed uric acid very persistently, but his blood pressure was never more than 110, pulse 72. Two brothers, aged 16 and 17, pass uric acid constantly in large quantities; the younger has a blood pressure of 120, pulse 72, and the elder, blood pressure 145, pulse 54. A man, aged 56, is gouty, and his urine constantly liable to deposit uric acid; his blood pressure is only 145, and pulse 72. A soft large pulse is, moreover, commonly met with in gouty people. Seven cases of headache were associated with uric acid; of these three were males and four females; three were over 40 years of age, and four under. One only showed a pressure over 150 mm., but that case was a woman with albuminuria; one only was below 120 mm., a boy aged 14; the rest ranged from 120 to 140, and were therefore within normal limits.

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Note.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by W. Hale White, M.D.Lond., F.R.C.P. Lond., Senior Physician to and Lecturer on Medicine at Guy's Hospital, on "Enlargements of the Liver."***

ORIGINAL PAPERS.

ON SUNDRY FORMS OF PSEUDO-RHEUMATISM OF TOXIC ORIGIN.

By M. S. LASSANGE, M.D.,

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[Specially Reported for The Medical Press and Circular.]

The articular troubles which affect a similarity to rheumatism—acute and sub-acute polyarthritis—fall into one of two categories—*e.g.*, pseudo-rheumatism of infective origin, and true articular rheumatism. Apart from true acute articular rheumatism, which is, in all probability, a morbid entity caused by a specific organism, we sometimes meet, in the course of intoxications, with articular manifestations of an acute character which strikingly resemble true rheumatism. These may be grouped under the term pseudo-rheumatism of toxic origin. There are consequently three varieties of rheumatism—true articular rheumatism, infective pseudo-rheumatism, and toxic pseudo-rheumatism.

PATHOGENESIS.

Bacteriological research has not as yet determined the specific organisms of rheumatism, so that we are tempted to look for what our forefathers called "the peccant humours," which, in the light of our present knowledge, may be taken to mean toxins, poisons which are elaborated in, or introduced into, the organism, and set up changes in the blood, lymph, and intercellular plasma. As a matter of fact, the nature of these poisons has not as yet been clearly defined; yet the predominating factor in the pathogenesis of toxic pseudo-rheumatism is individual predisposition. This predisposition, which amounts to a genuine idiosyncrasy, has for effect that the individual will suffer from more or less marked rheumatic manifestations in the course of an intoxication which in another would be wanting, and its place taken by a toxic eruption. We recognise this predisposition without being able to define it. It may, of course, be inherited, but what is transmitted is not rheumatism itself but rather a predisposition to contract that disease. Are there not, however, toxins which, when present in the blood, exert a selective action on the joints? It is highly probable that such is the case, for in these cases the poisons attack the articular and peri-articular structures, setting up inflammatory lesions characterised by pain, swelling, and loss of function, and determine complications in the big serous membranes —endocardium, pericardium, pleura and meninges. It is therefore impossible to gainsay the selective action of certain poisons on articular and peri-articular tissues, but this influence does not always manifest itself, and, moreover, it does not explain all cases. It is probable, too, that in many instances the articular troubles in toxic pseudo-rheumatism are consecutive to changes in the nervous system brought about by the intoxication. This is not a new view, for Reveillé-Parize wrote:—"There is one view which was at first lost sight of, for it goes very far back, but is now rapidly gaining in favour. Many practitioners hold that rheumatic and muscular pains, whatever their distribution, are originally dependent on an affection of the spinal cord, this being manifested by the sensitiveness of certain points in the spinal region." This view is admitted by Friedlander, and recently by Trollard, of Algiers. It may consequently be conceded that the poisons are capable of acting on the articular centres of the spinal cord, in support of which view may be mentioned the frequency of polyneuritis, paralysis, and psychical disturbances in the course of various intoxications.

CLINICAL DATA.

We will begin with the exogenous poisons that may determine arthropathies simulating rheumatism. Alimentary toxins often give rise to pseudo-rheumatism of variable severity, which Bouchard believes to be due to the ingestion of the ptomaines and toxins present in decomposed meat. Friquet, in his thesis, collected numerous instances of alimentary intoxication followed by articular pain and synovial exudation which proved refractory to the salicylates. Moreover, instances are on record in which alimentary intoxication has given rise to epistaxis, dry pericarditis, double pleural effusion and mitral endocarditis.

Certain medicinal poisons—chloral, quinine, antipyrine, copaiba, and iodoform—have been known to cause similar symptoms. According to Fraser, eserine, and, according to Gubler, colchicine, may also determine joint pain with profuse sweating. In cases of accidental poisoning articular disturbances have often been noted, as, for instance, in chronic poisoning by arsenic or copper. Lead poisoning deserves special mention in this connection, for not only do we get plumbic gout, but also acute attacks of joint pain, which Sauvages describes collectively under the term metallic rheumatism. The joints and muscles become very painful, and the symptoms are most severe at night. The etiology of all these cases is certain—viz., an intoxication which is or is not grafted on a pre-existing diathesis.

Articular affections due to endogenous poisons may be dependent on many causes. Of the poisons thus formed within the organism, some are due to vitiated metabolism. Under ordinary circumstances these poisons are eliminated by the emunctories without any trouble, but in presence of fatigue, over-work, and certain external causes the secretion of these toxins is increased by organic changes, and if the normal paths of elimination are obstructed, we are apt to get morbid disturbances, more particularly articular fluxions. This, indeed, was the reason that led our predecessors to ascribe an attack of rheumatism to the sudden suppression of normal or accidental evacuations, such, for instance, as profuse or local perspiration. When the bye-products of metabolism accumulate in the blood we get the uræmic state, and one variety of this uræmia is arthralgic, as to which Jaccoud says:—"This form must be rare, to judge by the silence of authors in respect thereof, but I wish to call attention to it, not as something new, but especially because it may tend to render the diagnosis obscure. I remember the case of a woman suffering from chronic kidney disease who was seized with very severe pains in all the joints. Next day she developed uræmic convulsions, which soon merged into coma; yet the joint pain persisted, for, even when coma was complete, pressure on the articulations was the only thing that changed the expression of her otherwise impassive face. At the same time she made reflex attempts to get away from the painful pressure. In another case, one in which the patient was found comatose in the street, pressure on the knees and other joints provoked inarticulate cries and contraction of the facial muscles. On examining the urine, we found it laden with albumen, and containing numerous casts. Post-mortem examination confirmed the diagnosis of renal disease." These joint pains occur not only in uræmia, but also in Bright's disease, showing that renal elimination is inadequate.

But even when the kidney is working properly, accumulation of the poisons may still take place if they are produced in too large quantities. In this connection we must examine the two principal sources of organic poisons—viz., a disordered digestive tract and microbial foci.

Digestive auto-intoxication has been thoroughly investigated by Bouchard, and among the disturbances consequent thereupon we get articular affections, not to speak of osseous deformities in the extremities (Heberden's nodes), or of slowly progressive joint troubles, reserving our attention for the more acute manifestations. These troubles, which may be associated with digestive disturbance, or may alternate therewith, present the greatest analogy with ordinary rheumatism. The articular pain is accompanied by loss of appetite, furred tongue, palpitations, dyspnœa, constipation or fœtid diarrhœa, often associated with disagreeable dryness of the throat.

The practical conclusion to be drawn from these facts is that, in the etiological examination of rheumatic manifestations, we must always bear in mind the possibility of digestive disturbances, and, when found to be present, instead of giving irritating medicines which would aggravate the condition, we must institute an anti-dyspeptic regimen and clear the intestines by repeated saline laxatives. This method of treatment will often succeed when the specific medication fails.

The so-called bilious rheumatism which occurs in the form of acute or sub-acute polyarthritis in the course of biliary cirrhosis or common cholemia, belongs to the same group. Rheumatism occurring during pregnancy is also probably a manifestation of gravid intoxication.

Now as to the microbial toxins. Can they determine similar arthropathies? We are hardly justified in asserting that such is the case; yet instances are on record in which pseudo-rheumatism associated with certain infections has been shown to be of toxic origin. When for therapeutical purposes we employ attenuated microbial toxins or the serum of an immunised animal, we not infrequently get eruptions and joint pains which are due to the seropathy. Articular pain strikingly resembling that of rheumatism is particularly frequent after injections of tuberculin and anti-diphtheric serum. Poncet, who has made numerous subcutaneous injections of tuberculin, looks upon these accidents as the result of intoxication induced by Koch's lymph, and he compares them with the outbursts of articular rheumatism which he has met with in non-rheumatic phthisical subjects supervening when the cough and expectoration have been arrested. He says:—"If, under the influence of a too efficacious medication, the natural emunctory represented by the expectoration is suppressed, the retention of pus and tuberculous products in the cavities gives rise to auto-intoxication. In such cases retention is an exchangeable term for absorption—*i.e.*, permeation of the organism by toxins produced in the pathological focus from which they can no longer make their way out. Articular complications may, under these circumstances, supervene in the form of acute articular rheumatism."

The toxic origin of certain rheumatoid arthropathies following the injection of anti-diphtheric serum was first called attention to by Dr. Moizard. In 1895 Gaillard brought before the Hospitals' Medical Society a case in which acute polyarticular rheumatism set in a fortnight after an injection of anti-diphtheric serum in a patient who had streptococcic angina, and was attributed by the author to the direct action of the injection. A child of 5 who had been given a similar injection by Dr. Sevestre developed a rosy eruption on the back of the hands, and the joints became swollen, with pain in the neck and vertebral column. Many such cases have since been placed on record, and the toxic origin of the articular troubles is now generally admitted. It follows that microbial toxins, even when the organisms themselves do not find their way into the joint, may give rise to arthralgia like that of rheumatism, and we can understand the distinction made by Poncet in respect of tuberculous rheumatism:—"Apart from specific or plastic tuberculosis with typically tuberculous products, there is an inflammatory tuberculosis which often assumes a rheumatic aspect. The bacillus is in this case wanting, and the case is one of toxic but not bacillary arthritis."

The same procession of events is seen in blenorrhagia and scarlet fever. Sometimes the articular manifestations are due to the intrusion of the microbe into the joint, and when this follows scarlet fever there is serous suppurative arthritis or suppurative arthritis *ab initio*, while in blenorrhagia we have pseudo-phlegmonous arthritis. In the other cases we get more or less disseminated polyarthritis, never followed by suppuration, in which bacteriological examination gives negative results.

CONCLUSIONS.

In all the cases referred to, the etiology of the articular manifestations is characterised by an intoxication bearing on subjects possessed of a special morbid predisposition which it is difficult to define but the existence whereof is incontrovertible. In some instances the intoxication is obvious, and constitutes the sole cause that can possibly be invoked, as when the poisons are of extraneous origin—*e.g.*, taken with the food, or in medicinal form, or by accident. In other cases the arthropathy appears to be due to toxins elaborated within the organism. In the last-named the intoxication is unquestionable, and its influence in the production of articular manifestations approximately certain, as has been shown, but it is then much more difficult to define the exact origin of the poison by reason of the complex and multiple reactions of the tissues.

But in virtue of what mechanism do these exogenous or endogenous toxins determine rheumatoid phenomena? In the present state of our knowledge, no answer can be vouchsafed, so we are fain to content ourselves with suggesting various plausible hypotheses based on the study of the pathological conditions. Moreover, it is highly probable that the mechanism varies according to the nature and the quantity of the poison.

However this may be, all the recorded cases present certain points of resemblance. Cases of toxic pseudo-rheumatism all have a certain family resemblance. Their analogy enables us to classify them and to differentiate them from a whole series of arthrites due to the presence in the joints of an infective agent.

Toxic pseudo-rheumatism may take the form of simple arthralgia or actual rheumatism strictly comparable with true rheumatism. The onset is sudden, is characterised by pain in a certain number of joints, remaining polyarticular for several hours, but soon becomes more pronounced in one or two big joints which remain affected longer than the others. The pain alone may persist, and it presents certain peculiarities. It resembles that of true rheumatism, as described by Lassègue. It is not really an intra-articular pain, but a sensation of burning tension or arthralgia around the joint, corresponding to the insertion of tendons or of the muscles covering it. Movement is more painful than pressure of the joint. The inflammatory phenomena that accompany the pain are, as a rule, not very pronounced; there is but slight swelling and redness, and intra-articular effusion, though possible, is exceptional. In short, it may be said of toxic rheumatism, in respect of the local symptoms, what Lassègue said of true articular rheumatism—viz., "that they are especially extra-capsular, whereas infective arthritis is essentially intra-capsular."

The characteristic physiognomy of toxic rheumatism is not exclusively due to the local symptomatology. Although in some instances they may seem isolated, and although the more or less severe articular pain sometimes constitutes the whole symptomatology of intoxication, in the majority of instances the arthropathy is only one feature of a whole category of disturbances usually regarded as of toxic origin. The most striking are the cutaneous manifestations so frequently met with in association with various intoxications—profuse sweating and diverse eruptions, prurigo urticaria and polymorphous erythemata.

The course of toxic pseudo-rheumatism is sufficiently characteristic. The acute attacks are remarkable for their comparative mildness, their ephemeral duration, and the variability of the phenomena. But in the long run, should the attacks be repeated, as may happen in the course of chronic intoxication, it ends by the formation of plastic products manifested by crackling, with dull, persistent pain.

These characters and this course enable us to distinguish the arthropathies under consideration from the microbial arthrites which only attack one joint, or only a few joints, remain localised therein, and are often followed by suppuration.

To conclude, it may be stated that a poison that has permeated the organism in predisposed subjects may give rise to articular disturbances very similar to those of true rheumatism, and these rheumatoid phenomena resemble each other closely enough for it to be justifiable to classify them in a special group—the group of toxic pseudo-rheumatism. Lastly, although it was not our object to revive the theory of the toxic origin of ordinary articular rheumatism, such theory being notoriously inadequate, it is probable that the causes of toxic pseudo-rheumatism, together with the cases of infective pseudo-rheumatism, will be found to cover the great majority of cases still regarded as true articular rheumatism. For, should a specific agent be discovered in this affection, it will always be possible to relegate it to one or other of the two groups of pseudo-rheumatism already established. In some instances, indeed, this agent may be localised in a joint and set up a rheumatic arthritis, this being an infective accident; in other cases, when the blood merely conveys poisons elaborated by this agent in the tonsils, or perhaps in the intestine, these poisons may, either directly or *viâ* the nervous system, act upon the joint structures and give rise to purely toxic arthropathies.

THE RAVAGES OF TUBERCULOSIS IN IRELAND. (*a*)

BY R. F. TOBIN, F.R.C.S.I.,

Surgeon to the Hospital.

THE statistics of the death-rate from this disease, the only official information we have of it since it is not notifiable, are pretty generally known. Still, as you may not have meditated on them as you should with your morning prayers, I shall briefly lay them before you. I quote the Registrar-

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(*a*) Being a Lecture Introductory to the Session 1907-8 of the Medical School at St. Vincent's Hospital, Dublin.

General. In his report for 1906, under the head of tuberculosis, he says:—"I find that there were 11,756 victims, inhabitants of Ireland; in other words, out of a total of 74,427 deaths registered in Ireland during the year 1906 no fewer than 11,756, or 5.8 per cent., were sacrificed to a disease which is in a great degree preventable. Year after year these facts are published, and although the members of the medical profession are strenuous in trying to awaken the public to a state of affairs that can only be considered as destructive to the community, yet, comparatively speaking, our countrymen are not alive to the dangers which threaten them." In another part of the same report he points out that "by far the greater number of the descendents were in the effective age periods of life, the highest number for both sexes falling in the age period between 25 and 35 years." In another column the average annual death-rate from tuberculous disease during the last five years is shown to be over 12,000.

Now, it has been calculated that the ascertained mortality from tuberculous diseases may be safely multiplied by ten in order to represent approximately the number of persons living and seriously affected in the area in which the deaths occurred. Doing this with the figures before us we arrive at the appalling fact that there are at this moment 120,000 people scattered over this country suffering in a more or less advanced degree from this infectious disease. In my opinion this calculation is under the mark, for patients suffering from tuberculous disease in outlying parts of the body are much more numerous than patients suffering from phthisis pulmonalis, and they generally live a long time. It is also interesting to compare the statistics of population, and of disease, in Ireland and Scotland. On doing so during the last sixty or seventy years we find—I am roughly speaking—that while in Scotland tuberculous disease has fallen one-half, and the population has doubled, the reverse is the case in Ireland. Tuberculosis has markedly increased, and the population has fallen one-half. Surely these are facts we should let sink deeply into our consciousness. Now, carry your attention to this further view of the situation. You are all aware that in actual warfare the degree to which the effectiveness of an army is diminished by deaths, wounds, and disease is not computed by merely substracting the loss so occasioned from the total strength. There are other factors to be considered. The effects on the morale of the troops of a large sick rate and death rate, the numbers required to wait on the sick, the degree to which their transit blocks the lines of communications, the extent to which they in various ways hamper the efficiency of the men in health. All these have to be taken into account before you can judge of the degree to which sickness impairs effectiveness. Will anyone say it is different in civil life? That the sick child or the sick wife doesn't hamper the whole household, that the morale and earning power of its strongest hand is not impaired by the weak one; that he is not a depressing influence far beyond his own home. You, no doubt, feel inclined to interrupt me by saying:—"We have all felt it, we all know it." My answer is, measure it, multiply it by one hundred and twenty thousand, and there you have the extent of an omnipresent force called into existence by these bacilli over and above the killed and wounded that they claim. It is, as I have said, an appalling bill. It raises the question, is not this the question of questions and ought not all other questions stand aside until it is solved?

It is now some years since Pasteur gave to this world an announcement which stands only second to another "message of great joy," and one, the truth of which, as time goes on, is more and more recognised by the scientific world. "A day will come when in Berlin, in London, in Paris man will not die of diphtheria, of typhoid, of scarlet fever, of cholera, or tuberculosis any more than he dies in these cities to-day from the venom of snakes or the teeth of wolves." It is interesting to contemplate the different use made of the scientific fact contained in this announcement by two distinct nationalities. We, who are imbued with the conceit and pusillanimity of Western civilisation, heard it and went our way on motor cars, tram cars, bicycles, shoe-leather and bare feet as if nothing at all had been said. So much so that when Sir Frederick Treves repeated this same sentence quite recently, we received it as something quite new, and he had to write to the papers to say that it was to be found at page 129 of Frankland's "Life of Pasteur." Japan also heard it, as it lay in terror of extinction by the Muscovite flood then spreading in the East. Dare they draw the sword on Russia? If they were to do so they would lose 50,000, perhaps, 100,000 in fair fight. They were satisfied to bear that loss. But what of deaths from disease? They knew the following figures collected from the history of warfare, "of every hundred men lost in war twenty die from fair fighting, eighty from disease." I can answer for these figures, for I was assistant to Longmore when he was compiling the tables that bear his name, and on which they are founded. With these statistics before them the drawing of the sword seemed hopeless. Fifty thousand deaths from wounds meant an additional two hundred thousand deaths from disease, and putting the mortality as high as 1 in 10, this number of deaths from disease meant two million cases of sickness. If you call to mind what I have already said of how a large sick list in warfare interferes with effectiveness, especially when operations have to be carried on at a distance from the base, you will see that their case was hopeless. It was a pitiable state of things, for the love of race was strong in them. Then they heard the message of Pasteur. They realised what could be done by a successful application of his discoveries. We know the rest. We know where Japan stood then and where she stands now, but listen to the figures of the fight. I give them from a book I would advise everyone to read, "The Real Triumph of Japan," by L. L. Seaman, who was in the position of a military attaché to the Japanese Army during the war:—52,946 killed in fair fight, 11,992 killed by disease. They are results that cry "pause" to European civilisation. Let me indicate the main features of the measures by which these results were obtained. The medical profession was placed, as regards position and power, not above or below, but on a level with the other great departments of the State. So placed it was found worthy of the trust reposed in it. Its members studied not Squire's Pharmacopœia and the Dictionary of Treatment, but the works of Pasteur and Koch and Parkes and their many followers. Sanitation was made the first duty of medical officers. If a regiment with one medical officer was engaged in an action on its way to a certain camp, and there were, say, twenty wounded, the surgeon on arrival allowed the wounded, to whom, when they were picked up, first dressings had been applied, to lie on their litters till he had looked into everything likely to affect the health of the men. The water was tested, and the wells marked fit or unfit for drinking. If there was no good water, what there was was filtered or preferably boiled, and, rice being added, it was both a safe and nutritious drink. So on with other things. Finally every soldier was given an elementary idea of the rules of health, and these soldiers (herein lies the strength of Japan) had the self-restraint and the patriotism to do what they knew was right. How do we act here? What of our knowledge and self-restraint and patriotism? We see a secret foe spreading over the country practically unopposed, killing and maiming and scattering its inhabitants.

As a race we are nearer to extinction than were the Japanese. What are we doing? Is the fate that threatens us the fitting outcome of our ineptitude? Here a word about the position of the medical profession in this crisis is required. Where are we, and what are we doing? We are in the position assigned us by the public, by whom, it is said, we are valued, but apparently not sufficiently so to induce them to make us responsible for the conduct even of affairs of health. We have no power and we have very little influence in the State. We are not men like judges, generals, magistrates, policemen, who draw their incomes from the public purse, and who are, therefore, from a pecuniary point of view independent of the good opinion of their neighbours. On the contrary, we, as a profession, are dependent for the means of living on fees received from individuals from day to day. The good opinion, therefore, of that representative person, the man in the street, not in a general, but in a particular way, is necessary to us. This notwithstanding, we are for ever preaching hygiene, temperance, and other unpleasant truths to people who don't want to hear. Can you expect more from us? Can you ask us to refuse you, after you have been duly warned, the thing you demand? Medicine is a great and noble profession; still its members have in them some human nature, and some appetites, for the satisfaction of which fees and not ideals are required. Now what do the public want in this matter of tubercular disease? They want treatment and liberty. Treatment according to some of the recognised forms, since there is no cure—liberty to scatter their bacilli over the land. Now as to preventive medicine. There are, I am told, only two men in the whole of Ireland who are paid to give their whole time as sanitary officers. There is also, it is true, a medical officer of health in every town and dispensary district; but you can only judge how far he meets the requirements of the situation when you know what is his salary—what his equipment. Has he a diploma in public health? and, above all, are his hands free?

Now let me sum up the case before you. There are in the country one hundred and twenty thousand cases of tuberculous diseases. An infectious disease, a preventible disease, a disease that means sickness extending over years, bringing death and disablement to those it attacks—sorrow and ineffectiveness to those who escape. This fact, made clear to us by statistics, is confirmed by the state of affairs in general. You can apply the term decline to the condition of the country as truly as you can to an advanced case of phthisis in the wards. Things will not mend of their own accord. On the contrary, if nothing is done, they will grow worse. For the disease is scattered everywhere, spreading its germs as a daisy does its seeds. That is the first point. The next is that means are at our disposal to tackle this great plague, but the great majority of the public do not care. They do not really care. They will not focus their attention on the question. There is no public purse-opening force in their sympathy. Their attitude is characterised by indifference and parsimony.

What is the first step in this state of things to be set right? Here are my views briefly. Nothing new, as I have already told you. Education, and again education, on the questions of public health for the cultured as well as for the working classes. Who is to be educated? Each individual Irishman. Not in any special way county councillors or members of Parliament, or even the English Government, but each man and woman and child who is given room on the land called Ireland. He is to be taught that health is the first duty, and the best economy, whether he considers himself or his country. Further, that the attainment of health consists in the carrying out of certain rules the enforcement of which lies partly at his door, partly with the corporations whom he elects to represent him. There will then remain only one question, "What About Compulsory Notification?" On this I hold very definite views. There are medium courses. Much could be done by admonition and supervision, especially if the number of nurses throughout the country were increased. One thing, anyhow, is certain —if notification were made compulsory, we would in a few years have very valuable information about this disease. There is no knowing what points it might bring out. That information being obtained, the whole question should be considered by all the councils collectively. They should combine and call to their assistance the best advice the world can provide, and thereupon with full information before them, they should decide on what measures to take, just as if it were a question of drainage or of water supply.

There is much else to be said, but you will joyfully agree there are limitations to an address. We must, however, not let pass without recognition what many enthusiastic men throughout the country, what the Registrar-General, the National Society for the Prevention of Consumption, and the Women's National Health Association of Ireland have been doing.

THE SPONTANEOUS FRACTURE OF URINARY CALCULI. (*a*)

By T. R. BRADSHAW, B.A., M.D., F.R.C.P.,

Physician to the Liverpool Royal Infirmary.

THE occurrence of spontaneous fracture of a urinary calculus followed by expulsion of the fragments through the urethra, though it has been recorded from time to time, is a comparatively rare event, and I think that an account of an instance I have met with in my own practice will not prove without interest.

The subject of the condition is a gentleman, now in his eighty-first year, who led an active professional life until ten or twelve years ago. About twenty years ago he began to pass small uric acid calculi *per urethram*, and this has continued at intervals up to the present. They were generally the so-called "mustard seed" calculi, but sometimes much larger. One, which is shown in fig. 1, passed in 1891, measures ⅜ in. by ¼ in., and weighs 325 mg., about 5 grains. The urine was almost always acid, and in every respect normal, except that it seemed deficient in colouring matter, and on standing deposited crystals of uric acid more quickly than usual. For many years there has been a good deal of irritability of the bladder, with frequent micturition at night; but there is little, if any, prostatic enlargement, and the urine is at the present time quite free from excess of mucus.

On October 22nd, 1901, hæmaturia was noticed for the first time, and it has recurred at intervals until the present. The quantity of blood was generally small; it was thoroughly mixed with the urine, and was most noticeable after exercise. It was seldom present in the morning, but was very frequently noticed after a walk of a mile or two, sometimes after a carriage drive. I came to the conclusion that my patient had a renal calculus, but, in consideration of his advanced age, and of the fact that his general health was not compromised, I did not entertain the idea of operative interference.

On January 5th, 1905, Mr. T. T. Holland took radiographs, and determined the presence of two calculi in the right kidney. After this the patient began to suffer from occasional painful attacks in the right side of the abdomen, attended with tenderness in the right iliac fossa, and slight pyrexia. Whether these were due to renal colic or to appendicitis there was a good deal of doubt, but on May 30th, 1905, he was suddenly seized with an agonising pain in the right side of the abdomen, which was undoubtedly of renal origin. Similar slighter attacks followed. In January, 1906, he began to pass fragments of calculus, and continued to do so during several months. At the same time his general health improved. He found he could take exercise without inducing hæmaturia as readily as before. In his own words, he felt as if he had got rid of something. On June 1st, 1906, he had a rather sharp attack of renal colic, and on June 16th he began to pass fragments, and continued to do so for a few days. These, when collected, weighed about 14 grains. One can hardly doubt that the colic of June 1st was connected with the descent of a calculus which disintegrated, and was evacuated piecemeal. Again, last November, more fragments appeared.

As to whether this process is likely to end in the complete removal of the calculi, I am not prepared to offer a positive opinion. I can only say that my patient can now (May, 1907) take his usual exercise with a degree of immunity from bleeding which he has not enjoyed for some years past.

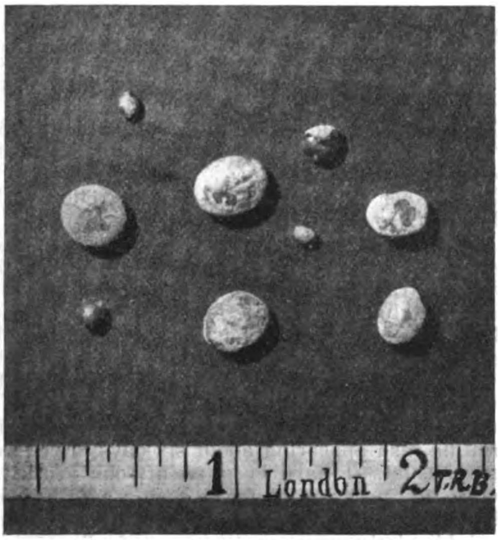
The treatment adopted was extremely simple,

(*a*) Paper read before the Liverpool Medical Institution, November 22nd, 1906.

the object aimed at being to reduce the nitrogenous intake to the smallest amount compatible with the maintenance of nutrition, to keep up a flow of urine, and to maintain the general health by moderate exercise, regularity of life, and the avoidance of fatigue. When the uric acid calculi first appeared, my patient, always an abstemious man, reduced his diet still further. He became to a considerable extent a vegetarian, lunched chiefly on milk puddings, seldom touched butcher's meat, dined chiefly on white fish, and gave up drinking wine altogether. From time to time, especially when calculi were passed, he used to take small doses of citrate of potassium, 5 grains once or twice a day; never enough to make the urine alkaline.

The possibility of urinary calculi being got rid of by a process of spontaneous lithotrity, such as has been going on in my patient's case, does not seem to be generally recognised in text-books of medicine or surgery. I can find no mention of it in Mr. H. Morris's "Surgical Diseases of the Kidney and Ureter," nor in Prof. Osler's "Practice of Medicine." The late Sir Wiliam Roberts, in his great work on "Diseases of the Kidneys," discusses the possibility of dissolving calculi, but does not allude to the possibility of their breaking up. Nevertheless, several cases are on record. Dr. Prout (1), in 1848, speaks of several instances as having fallen under his notice, and describes at length one case, that of a gentleman, æt. 90, who, after suffering from symptoms of stone in the bladder, began to pass fragments of uric acid which had evidently formed portions of a calculus, and continued to do so occasionally for more than a year. In the museum of the Royal College of Surgeons there is an example of spontaneous fracture which was met with in the practice of Mr. Southam, and in 1876 a case was related to the Pathological Society by Dr. W. M. Ord (2). This patient, a gentleman, æt. 83, passed an enormous number of fragments, which appeared to be segments of multiple calculi, consisting of uric acid and urates. Subsequently Dr. Ord reported several other cases in his own practice and that of others, and ten cases were classified and collated by Wilberforce Smith and E. Hurry Fenwick in 1890 (3).

Fig 1.



Scale of Inches.

Another notable case was that of Kraus, of Carlsbad, where a man, æt. 78, some months after undergoing the "kur," passed fragments representing the débris of nearly thirty calculi (4).

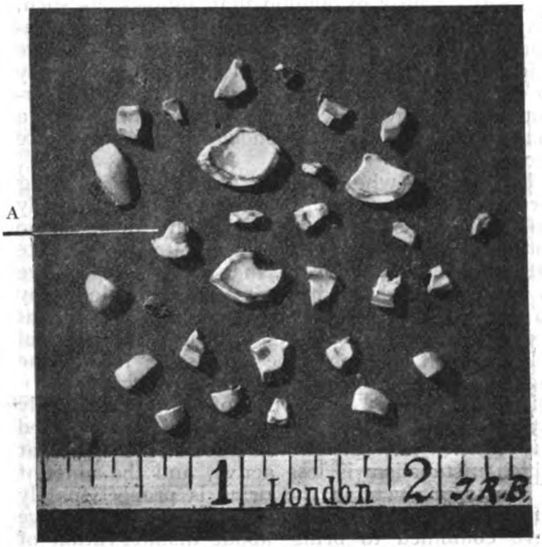
At the Egyptian Congress of Medicine, 1902, Mr. Reginald Harrison reported a case where a gentleman undergoing treatment with borocitrate of magnesia passed a large number of fragments, and I believed it is claimed for various spas that the same result may follow the use of the waters.

Two questions present themselves. By what means is the fragmentation brought about, and is it possible to promote its occurrence by therapeutic measures?

1. Dr. Ord (5), noticing that the nucleus was absent from every fragment which he examined, suggested that an expansion took place in the nucleus and led to disruption of the calculus, as of a shell by a bursting charge. Opposed to this view is the fact that one of my specimens shows a perfect nucleus lying *in situ* with a large fragment attached to and partly enveloping it (see *a* in fig. 2).

2. Dr. Ord thinks that in one case he found the mycelium (6) of a fungus growing on the fractured surfaces. If this was the cause of the breaking up of the stone we must admit the possibility of various agencies bringing this result about.

Fig 2.



Scale of Inches.

At A is seen a fragment with nucleus attached.

3. A varying degree of acidity of the urine has been supposed to cause solution of certain of the layers of a porous stone by undermining the superficial parts. Of this theory we may say that as varying degrees of acidity are the rule and not the exception, if it were true, spontaneous fragmentation should be much more common than it is.

4. Bigelow suggested that the human bladder can crush stones as the human hand can crush walnuts.

5. Finally, we have the old suggestion of Dr. Prout (7), elaborated in a somewhat different form by Mr. Plowright (8), that certain calculi have a distinct radial structure, with a tendency to lines of cleavage, running from the centre towards the circumference. Of the truth of this view anyone may satisfy himself by inspecting the uric acid calculi shown in section in a pathological museum. There are some excellent instances in the museum at the Liverpool University.

In reviewing the explanations offered, one is inclined to wonder, if they are true, why spontaneous disintegration of calculi is not a common occurrence, instead of being, as is universally admitted, an event of considerable rarity. The true cause must be a circumstance, or a combination of circumstances, rarely present in the subjects of calculi. Further, whatever the conditions may be, once established they tend to persist, for experience shows that when the fragments of calculi have once appeared we may expect a repetition of the occurrence during months or years to follow. Finally, there is strong reason to believe that uric acid calculi alone are capable of undergoing spontaneous disintegration.

Mr. Buckstone Browne (9), who reported two cases in 1890, puts the following leading question: "Does the alkali in the water of many a watering-place really deserve the credit of breaking up and bringing away stones; but, rather, is not the disintegration of the calculi due to their being bathed by healthy urine, the result of drinking freely of *water*, and of the fresh air exercise and somewhat restricted diet usually imposed on the frequenters of these health resorts?"

I am strongly of opinion that alkalies, as such, play but a very subsidiary part in the disintegration of calculi, and that the attempt to dissolve calculi by bathing them in alkaline urine is likely to defeat the object in view by leading to the formation of a layer of phosphates on the stone, a material which has no tendency to disintegrate spontaneously.

Dr. Prout, whose views as to the radiating structure of many uric acid calculi I have already referred to, points out that healthy urine is so constituted as never to be in a state of complete saturation even when cold, that at the temperature of the human body its point of saturation may be supposed to be still further raised, and that healthy urine is probably one of the most powerful solvents that we can hope to possess for all the ingredients likely to exist in urinary calculi. In this connection it is worthy of note that nearly every case of spontaneous disintegration recorded has been in a man who has reached an age at which metabolism is less active, and the amount of waste products in the urine is proportionately diminished. The circumstances which I believe have combined to bring about disintegration of the calculi in my case, and in others like it, are very simple, but, I suspect, not so frequently found together as one might suppose. They are the maintenance of the urine in a healthy condition, the presence in that secretion of abundance of water, and the reduction to a minimum of the products of nitrogenous waste.

Note.—Chemical analysis of the fragments shows that they consist almost entirely of pure uric acid. There are traces of sodium and ammonia. The fragments vary in colour from almost pure white to rich pink, but the majority are pale yellow ochre.

Addendum, October, 1907.—The patient remains in good health. During the last two months he has passed numerous fragments of uric acid calculi.

References.

(1) Prout, "On the Nature and Treatment of Stomach and Renal Diseases," 5th ed., p. 433.
(2) "Path. Soc. Trans.," xxviii., p. 170.
(3) *Ibid*., xli., p. 183.
(4) *Ibid*., xxx., p. 314.
(5) *Loc. cit.*
(6) "Path. Soc. Trans.," xxxii., p. 304.
(7) *Loc. cit.*, p. 435, footnote.
(8) "Path. Soc. Trans., xlvii., p. 132.
(9) *Ibid*., xli., p. 188.
(10) Prout, *loc. cit.*

CLINICAL RECORDS.

ACUTE NEPHRITIS AND SCARLATINA.

By THOMAS P. CODD, L. & L.M., K.Q.C.P.I., L.R.C.S.,I., L.M.,

Rotunda, Dublin.

The following case which came under my observation may be interesting to some of your readers.

It was a case of acute nephritis, which developed afterwards into scarlatina. A girl æt. 11, pale, thin, and of a delicate nature, was brought to me by her father on August 8th, 1907, suffering from stomatitis, for which I prescribed a weak solution of Condy's fluid as a mouth wash. Three days after, her father left at my house a 4 oz. bottle of urine, smoky in colour. On examination, it was found to contain blood, and to be highly albuminous. He called in the afternoon to tell me that the child seemed apparently well, except the condition of the urine; that she was running about, and, in fact, he was going to bring her up to my house, not thinking there was much wrong. Being rather an anæmic child, I gave her a mixture of liq. ferri. perchlor., and recommended her to be kept in bed, and get barley water and a little chicken jelly.

I called to see her the next day. Pulse normal, temperature 99 deg. F., no sign of any rash whatsoever, but inclined to be sick.

The mother could not understand when I told her the danger the child was in, and that she should be kept in bed.

The mother said she would like the child to be in hospital, so the same day she was admitted to the children's hospital. On examination, they could not detect anything unusual (except for the urine); no rash or high temperature. Four days afterwards the father came to tell me that a rash had developed, which was pronounced to be scarlatina rash; consequently the child had to be sent to the Fever Hospital, Cork Street. The peculiarity of this case, acute nephritis setting in first, and with such trivial symptoms, and the scarlatina rash appearing about six days after, was most unusual. I have been twenty-one years in practice, and never came across such a case before; perhaps some of your readers have. I understand the child's kidneys are acting very badly at present, and are only secreting 2 oz. of urine in the twenty-four hours. The blood has disappeared, and the albumen still continues.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Case of Intestinal Obstruction.—Mr. Joseph Cunning operated on a girl, æt. 12, who had been admitted at midnight the previous night. She had gone to bed at 11 after eating a number of green pears during the evening. She woke about midnight with acute pain in the abdomen, vomiting and diarrhœa. She was then brought to the hospital. She was on admission suffering from colicky pains, with a short interval between, pulse 80, temperature normal. On abdominal examination, the right half of the abdomen and the hypogastrium were occupied by a swelling shaped like a stomach, and during the colicky pains this swelling became more prominent and hard. It was resonant on percussion; there was no tenderness over it or rigidity of the abdominal wall. Rectal examination revealed nothing, and there was no passage or either blood or mucus. She herself said she had had a previous attack like this twelve months ago, and that since then she had had occasional attacks of sickness in school, but no pain. An enema was given, but with no result. During the night she was sick two or three times, but only stomach contents were brought up. A diagnosis was made of mechanical obstruction, which might be due to a band, as a result of the illness twelve months previously, or the case might be one of volvulus. The question of intussusception had been considered, but the tumour, which could be felt, was much bigger than the swelling usually present in intussusception, and it remained localised to the right half of the abdomen instead of progressing in the direction of the colon, and there had been no passage of either blood or mucus. Mr. Cunning before operating demonstrated the swelling and its increase in prominence during a period of visible peristalsis, and pointed out that this must be due to hypertrophy of the intestine. He then opened the abdomen through the right rectus, and found the intestine adherent to the abdominal wall by fine filmy adhesions. On separating these extensively it was found that the abdomen was divided into two halves, the left being occupied by normal intestine, the right by intestine covered with sheets of adhesions like fine tissue paper, with the exception of the middle of the tumour, which was constricted by a thicker band of adhesions, thus accounting for the stomach-like shape of the swelling. During the process of separating these adhesions the collapsed ascending colon and cæcum were discovered to the outer side, and the appendix was exposed; this structure was found to be the seat of a previous attack of appendicitis, which had resulted in the sloughing of the greater portion of its extent so that only about an inch of it remained; this stump was adherent to the tumour, which consisted of ileum, and all the adhesions apparently were the result of this attack of appendicitis. The stump of the appendix was separated and removed. The tumour was then investigated, and found to be many feet of the ileum rolled up in a concertina or accordion-pleated shape, the coils being held together by fine "chiffon"-like adhesions. When the dilated portion of intestine was exposed there could be felt in it numbers of firm masses, which were evidently the hurriedly chewed green pears. All the adherent coils of intestine were separated, and the abdomen was closed in three layers after it had been filled with normal saline solution in the hope of preventing the re-formation of adhesions. Mr. Cunning said that it had been clear that the patient had suffered from some chronic obstruction for a long time; it might be that the attack twelve months ago was one of intestinal obstruction, or it might have been one of appendicitis, for the only information to be obtained was from the girl herself, and she was too young to be able to give a proper account of her malady; the attack of appendicitis might have happened years before. The present attack of complete obstruction was due to the impaction of a hard mass of green pears in the ileum which was already kinked by adhesions. A patient might have a very small lumen in the small intestine, and yet get along comfortably owing to the liquid nature of the contents, but if large indigestible masses were swallowed, impaction was likely to occur and cause obstruction. He remarked that he had operated at once, although it was possible, but hardly probable, that the patient might have overcome the obstruction, but the danger of waiting was that if she did not overcome the obstruction the intestine would have become distended, and not only would there have been more difficulty in performing the operation, but there would have been the added danger of invasion of the wall of the intestine by the bacillus coli, and therefore the risk of peritonitis. Again, when distended intestine has to be handled, it is very difficult not to produce abrasions of the peritoneum, which constitutes one of the great risks of operating on such cases. With regard to the adhesions present it was interesting to note that in some cases of large localised appendicular abscesses, which had been drained, when the abdomen was opened several months afterwards, the adhesions had almost entirely disappeared, yet in such cases as the present one there was apparently no attempt at the absorption of the adhesions. For this peculiarity he would not venture to offer an explanation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Oct. 6th, 1907.

TREATMENT OF GONORRHŒA.

In presence of a patient suffering from a urethral discharge, the practitioner should first assure himself of the nature and length of time the discharge has been observed. If he has good reasons to believe that the affection is recent, dating from two to three days at most, I am one of those, says Dr. Carle, who consider that in such cases the abortive treatment should be tried.

A treatment of this kind should produce, in 48 hours, a complete relief of the acute symptoms—congestion, abundant and greenish pus, pain, painful miction and erections. In five days the discharge should be reduced to a drop in the morning, and at the end of a fortnight all symptoms of the disease should have disappeared.

At the first visit Dr. Carle commences the treatment by injections of a solution of permanganate of potash (4 grains to the quart). With a syringe containing half an ounce of liquid, he makes a series of injections (four or five injections are sufficient), each retained a few seconds. Three hours after a second series is made by the patient himself, and repeated every three hours (day time) up to the sixth day. From the sixth to the tenth day three series of injections only per day, then two during the two or three following days, and finally only one, in the morning. After the fifteenth day, if no discharge is perceived in the morning, which is generally the case, the treatment ceases.

Under this treatment the acute symptoms subside after 48 hours, miction is easy, congestion has diminished, and pain has almost disappeared. Towards the fifth day the running is reduced to a drop in the morning, but otherwise, if three hours after micturition, a drop of pus is observed to ooze out, the abortive treatment has failed, and the malady will likely run its course of six weeks.

The chief feature of this treatment lies in the multiplicity of the injections with a weak antiseptic solution. No internal treatment is necessary.

Out of 27 patients treated by Dr. Carle, 22 were definitely cured.

PERUVIAN BALSAM.

The value, as an excellent and easy dressing for wounds of all kinds, of Peruvian balsam seems to be recognised by many surgeons on the Continent. In one hospital, all recent accidental wounds have been treated systematically for the last two years with this substance. After carefully removing from the wounds all extraneous matter, the dressing is applied and not repeated for a few days.

Of 25 complicated fractures, thus treated, there was but one death from traumatic pneumonia; the remainder recovered without difficulty. Traumatisms of the hand and the foot with open fractures, gunshot wounds, wounds of every kind, in fact, were treated successfully by the balsam. Tetanos was only observed three times out of 552 cases.

HYPERÆMIA OF THE PHARYNX.

Hyperæmia of the pharynx is a symptom of either nephritis or diabetes when no other has as yet existed. Sometimes it appears a little before either sugar or albumin can be detected. But there is no means as yet of knowing to which of these maladies the symptom will belong. Local treatment avails nothing; the general condition of the patient should be treated. The patient should be kept under observation, and put on a diet special to either of these maladies; abstention from sugar and a milk diet ordered. If it turns out to be a case of Bright's disease the milk régime will be made absolute; if it is one of diabetes the patient will be allowed milk and Vichy water, and the usual remedies prescribed.

GERMANY.

Berlin, Oct. 6th, 1907.

THE seventy-ninth meeting of the Naturalists' Society was held in Dresden from September 15th to the 21st, Professor Naunyn in the chair.

After the transaction of the customary formal business, the report of the commission of inquiry into the state of education was received. Professors Gutzmer, of Halle, and Klein, of Göttingen, were entrusted with the drawing up of the report. The Commission issued a series of questions respecting scientific education to the higher teaching institutions in Prussia. It appears from the answers received that 77 per cent. of the higher schools were in favour of practical physical school exercises. Practical chemistry was taught in most of the Realschulen, and ought to be generally. The equipment for teaching the natural sciences was, however, at present inconsiderable. A central depôt for the furnishing of physical apparatus was not indicated, but a museum of natural science-teaching material was very desirable. Students should be insured against accidents in experimenting and excursions. The Commission should now be dissolved and replaced by a general committee of education. The Government were in general inclined to reforms. The necessity of biological instruction in the higher classes of the advanced schools was recognised. Teachers should not be called upon to teach in subjects in which they had no practical knowledge. Education in the University ought to be purely scientific, and by no means limited to one object (should be Kein blosses Zweckstudium).

The first scientific general address was by Prof. W. Hempel, and had for its subject "The Treatment of Milk." He pleaded for increased prices in order that the agriculturist might be able to supply an immaculate milk. Mothers' milk was unreplaceable, and at present success had not be obtained in the destruction of the bacteria of decomposition and of the bacilli of tubercle, and for this reason he was in favour of getting the milk of the healthiest possible cows in the cleanest possible manner and using it unboiled, or raw. Cows are best kept on the land, and we ought to try to get the milk forwarded in cooled vans. Only animals that did not react to tuberculosis and showed no signs of other disease should be made use of for the supply of milk.

Prof. Kelling, Dresden, gave a report on his biochemical blood-serum examinations, and recommended that in giving the injections of blood, as Bier had suggested, for carcinoma, the blood should be specialised, that was, those kinds of blood should be used that were furnished by animals against which the bodies of the tumour patients were known to react, and the injections should be used in the first instance for the purpose of producing immunity against recurrences.

Prof. Eber, Leipsic, spoke on the importance of Behring's

TUBERCULOSIS IMMUNISATION PROCESS

for combating bovine tuberculosis. He was of opinion that the resisting power of young animals against artificial infection with virulent tuberculous material could be not inconsiderably heightened by preliminary treatment with tubercle bacilli of the most varied sources, but that this heightened power was not of long duration. There was as yet no proof that Behring's bovovaccination protected against natural tuberculous infection. Nothing had been published so far to show that any other method of combating bovine tuberculosis was superior to Behring's original protective inoculation.

Prof. A. Kuttner reported on 230 cases of

LARYNGEAL TUBERCULOSIS IN PREGNANCY.

In 12, artificial abortion was necessary, and in 9 it was successful, but in failed in 3. The result was favourable, however, in 7 only. In 15 cases tracheotomy or a similar operation was performed, but in only 4 with success; 200 of the women died either before delivery or shortly afterwards. Of 116 children 79 died. In the discussion that followed the paper, the opinion seemed to prevail that women with laryngeal phthisis who became pregnant should be warned of the great danger they ran on account of the pregnancy. Abortion should be induced if the tuberculosis showed a tendency to spread. In the latter months of pregnancy artificial interruption of it always had an unfavourable termination.

AUSTRIA.

Vienna, Oct. 6th, 1907.

LYMPHATIC LEUCOCYTHEMIA.

KIENBOCK exhibited to the "Gesellschaft für Innere Medicin" a male, æt. 47, from Constantinople, who was a business man in that city, and who suffered from a severe form of lymphatic leucocythemia. He consulted the doctor on December 19th, 1904. He had then large lymphatics the size of plums, besides packets the size of nuts. The spleen was 5 centimetres or two inches below the margin of the ribs, erythrocytes 5,100,000, hæmoglobin 14.9, leucocytes 185,000, of which 90 per cent. were lymphocytes, while the polynuclear neutrophile leucocytes were 3.5 per cent.

The patient was irradiated at intervals of two and three months, the application lasting 8 to 14 days at a time. The whole body was exposed at first, but finally only the spleen and glands. The doses were small throughout, not exceeding 2 to 4 quantimetric units. The effects of the X-rays on the spleen and glands were notable and rapid; they became decidedly less within two or three days. The leucocytes fell to average between 20,000 and 50,000. At the beginning of the treatment it might be stated a temporary rise took place, but soon fell again—the lymphocytes taking the greatest part in this increase, while the polynuclear leucocytes constantly decreased. The erythrocytes and hæmoglobins gradually fell, the former from 5 million to 4 million, and the latter in the same proportion—no granular red corpuscles could be observed in the examination.

For two and a half years the patient has had intermitting applications, but from the very beginning he felt stronger and better fitted for his business than he had for a long time prior to the commencement of the treatment. It is now four months since he was irradiated, but he felt well, although the glands were still slightly swollen as well as the spleen, and could be felt below the ribs by causing a deep inspiration.

The erythrocytes are now 4,000,000, and the leucocytes 18,000.

OBLITERATION OF AORTA.

Schrötter presented an interesting case of obliteration of the aorta at the arch or the ductus Botalli or Botalli region, as Hyrtl prefers to call it, having first been described by Dr. Botal, of Venice. The boy was ten years old, with the jugulars pulsating; this could be seen at a distance and corresponded to the carotid and subclavian. The arteries of the legs were better felt than seen, but no pulsation could be detected in the crural region.

The ductus Botalli is a relict of the embryonic form which in this case seems to have persisted and retained the collateral circulation through the arteria thoracica longa and intercostals which were greatly enlarged as well as the epigastric artery, which was almost free from convolutions in its function of descending aorta. One of the peculiarities of the case was the absence of palpitation!

MONGOLOID IDIOCY.

Friedjung presented a girl, æt. 16½, with that form of idiocy known as Mongoloid. Her external appearance had the characteristic symptoms: Small stature and stunted development. The face was short, suffused with a constant simper, forehead low, temporal bones depressed, and eyes with the Mongolian characteristics—distinct epicanthus and blepharitis. The mouth and nose were small, while the tongue was large, somewhat bifurcated. The cheeks were high and red, the ears small, and the jaws normal, the thyroid was normal to the feel, the speech explosive, confined to short phrases. Both hands were large, cold, and distinctly cyanotic.

Radical Cure of Hernia.

Bernhard has performed the most radical cure for hernia we have yet heard of. He practised the operation on dogs with perfect success. and has now performed with equally good results on man. The difficulty hitherto is the presence of the spermatic cord in the inguinal canal. Bernhard obviates this difficulty by separating the testis from the scrotum, and throwing it back into the abdomen, thereafter, entirely closing the ring.

Castration has always been considered too severe. This abdominal position preserves the physiological function, and provides an effectual means of closing the ring. The question arises: What will be the result if the testis become diseased and tuberculous or syphilitic inflammation arise? To avoid this, as a prophylactic, Bernhard splits the tunical vaginalis propria, which prevents hydrocele.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE PROBLEM OF THE INSANE.

In the eightieth annual report to hand of Murray's Royal Asylum, Perth, the Physician Superintendent, Dr. Urquhart, takes occasion to review the experience of a quarter of a century and to mention certain conclusions arrived at. The position of affairs regarding mental disease is that we have to deal with a constitutional malady, profoundly affecting bodily nutrition and secretion, mainly originating in hereditary defect, and issuing in a liability to repeated attacks of insanity. This generalized disorder (whether toxic by impairment of the bodily processes, or by bacterial invasion) brings the manifestations of mental disorder into line with other diseased bodily conditions, and leaves the mystery of madness on a par with the mystery of rheumatism, which is also of a cyclic character, quite different from those maladies which, like smallpox, appear to confer a future immunity upon the individual. All insanity is a defect—at least, a degradation of function, if not a degradation of structure. It is a mental reduction, characterised by a loss of the finer feelings, an inability to adapt, a loss of restraint on motor manifestations. The evidence for these opinions is rapidly accumulating. Never before have scientific observations been so numerous and so important relative to the study of insanity. These have become so wide and so intimately connected with all the ramifications of physiology and pathology, that it is difficult to keep pace with them; but if all the apparatus of our hospitals for the insane is not bent to the elucidation and treatment of bodily disease, they are *pro tanto* failures, obvious and indefensible. The general summary of results from 1880 to 1904 inclusive, shows that 982 patients were admitted—809 for the first time, and 173 as re-admissions. Of 809 persons admitted, 31 per cent. recovered, 39 per cent. were removed unrecovered, 17 per cent. died, and 12 per cent. remained resident. The results for cases (admissions or re-admissions) are nearly the same. The incidence of neuropathic heredity in these 809 persons is represented by 45 per cent. of hereditary insane, and 72 per cent. of hereditary neuropathy—*i.e.*, with family tendencies towards the graver neuroses, want of mental balance, alcoholism, and paralysis. An examination of the families of insane parents, however, showed that 47 per cent. of the children of insane fathers were alive and sane, while 29 per cent. were insane; 42 per cent. of the children of insane mothers were alive and sane, while 39 per cent. were insane; 33 per cent. of the children of insane fathers and mothers (both parents) were alive and sane, while 44 per cent. were insane. This morbid heredity falls heaviest on the eldest child, and rapidly diminishes with the number of children. There is, even in the most disastrous class, an effort towards regeneration, and a curability which does not greatly differ from that of insanity which is not hereditary in the first instance, although hereditary defect is apparent in depressing the final recovery rate, and raising the death-rate. Brief reference is also made to the effect of alcoholism, as there are so many misunderstandings and misrepresentations on that subject. A hundred and ten cases of chronic alcoholism were recorded among certified and voluntary patients. The total neuropathic hereditary amounted to 70 per cent.; nearly 43 per cent .were hereditarily predisposed to insanity, and nearly 22 per cent. to alcoholism. There is no doubt that the alcoholic patients received into asylums are generally and heavily burdened with a morbid heredity, and that their failure is analogous to that of the ordinary insane—a failure inherent in the organism, often made more manifest by environment. Mental stress is often alleged as the cause of intemperance, as the cause of insanity; the inevitable complement of the mental stress, however, is innate or congenital defect.

Turning to the statistics for the year, we note the high average of admission (45.8, as against 44.5 in 1906). There is also a large proportion of senile cases. The average age at the first attack of insanity, however, was 39.3 years. The general recovery rate of the asylum for the years 1865-1906 is 35.17; this year it is 27.02 (compared with 42.85 last year) on the number of admissions. The percentage of deaths was 6.72, the average rate of the institution being 6.17. The average daily numbers on the register were: males 71, females 63. The general health of the patients and staff has been good, except for an epidemic of diarrhœa in summer, and of influenza in spring.

The Reports of the Commissioners speak in high terms of the efficiency of the institution.

BELFAST.

The Corporation and the Treatment of Consumption.—At the last meeting of the Public Health Committee the draft agreement between the Forster Green Hospital for Consumption and the Corporation was read. The hospital is to provide and reserve twenty-five beds similar to the existing beds in the hospital for the sole and exclusive use of patients to be nominated by the Public Health Committee, and approved. The agreement is to continue for ten years, during which the Corporation shall pay to the hospital the sum of £2,275 annually. The Lord Mayor for the time being, the Chairman for the time being of the Public Health Committee, and two other persons as the said committee shall appoint, shall be members of the Hospital Board. The working of this arrangement will be looked on with great interest, as certain difficulties are obvious.

Tuberculosis Exhibition.—A meeting was held in the City Hall on the 1st instant, the Lord Mayor (the Earl of Shaftesbury) presiding, to make arrangements for a Tuberculosis Exhibition in Belfast. Sir John Byers, Professor Lindsay, Dr. Dempsey, and other medical men took part, and Drs. Thomas Houston and J. McIlwaine were appointed honorary secretaries.

Banbridge Nursing Society.—The annual meeting of this society was held in Banbridge, co. Down, last week, and the report read showed the usual busy year's work which one has learned to associate with district nursing societies. But it contained one item of interest to medical men which such reports do not generally give; it gave the number of cases sent to the nurse in different ways. Of a total of 119 patients, 81 were recommended by friends, 21 by doctors, 5 by clergymen, and 12 by members of committee. This looks as though the services of the nurse were not so often utilised by the local medical men as might be the case.

LETTERS TO THE EDITOR.

PROTECTION FOR BEAST, NOT FOR MAN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Years ago, and on numerous occasions since, you have allowed me to point to and discuss, when called for, the fact that the Veterinary Act affords greater protection to the profession and the public than the Medical Acts. This is exemplified once more by a case reported this week. At Feltham Petty Sessions, on September 30th, a man was summoned for using the description, "canine and feline medical expert," implying that he was specially qualified to practise a branch of veterinary surgery. Although the man was ably defended, and it was not proved that he had actually suggested to his clients that he was a veterinary surgeon, he was convicted and fined 20s. Under the Medical Acts such a conviction is at present impossible, and there exists no functionary or public body like the Veterinary College, charged with enforcement of the law, even if it were applicable. Whether guilty of no greater real harm than the man in the present case, or carrying on the grossest system of cruel quackery and extortion, the unqualified medical practitioner cannot be prevented from palming himself off as a duly qualified man. He can employ language in his advertisements capable of deceiving not only the ignorant but the educated public, and there are hundreds of such men carrying on their nefarious trade throughout the country. It is impossible to believe that the Legislature would allow this state of things to continue if once the facts were forced to the knowledge of responsible men and statesmen. It needs no elaborate proof to show that it is at least as important to protect suffering humanity as suffering brutes against the injury which ignorance, incompetence, and dishonesty can inflict upon them. It is, I hold, the duty of the profession to take up and force to the front the question of medical law reform. As a preliminary step the case for legislation must be made out clearly and beyond dispute; and as nearly the whole of the newspaper Press, high and low, is suborned in support of quackery, this can be done only by means of an authoritative inquiry such as, I believe, would be afforded by a Royal Commission.

I am, Sir, yours truly,
HENRY SEWILL.

Cavendish Square, October 1, 1907.

A NEW ERA IN MEDICINE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the *Times* of October 1st there appears a remarkable article under the above heading. It is printed in the form of editorial matter, and I do not know whether the editor is responsible for it, or whether it is, after all, merely a paid advertisement. The sub-heading refers to a "Remarkable address at the opening in London of a West-end home of a famous Continental spa cure," but not a word of any address is to be found in the article. According to its promoters, this so-called "St. George's Nauheim Institute has been founded to meet the demand for progress by both patient and physician," but who the patient is, and especially who the physician, the article does not tell. We are, however, told that readers of the *Times* who want to know may learn all about it by applying at the Institute for a copy of the "handsome opening Souvenir Book," a work which we are further informed "must prove of vital import to readers who have personal reasons for desiring acquaintance with the latest methods that mark this new era in medicine." If your reporter was not present at the opening ceremony, I trust that one of your ablest representatives will be at once despatched, so that your readers may not remain long in suspense before they are enabled to take advantage of "the new era in medicine," and pass on their knowledge for the benefit of their patients.

I am, Sir, yours truly,
RUSTICUS.

October 3rd, 1907.

[*** The article referred to by our correspondent has appeared in several newspapers besides the *Times*. Although typed as editorial material, it is a cleverly concocted advertisement, and is paid for as such.—ED. M. P. AND C.]

CONGENITAL ANOMALIES OF THE EYE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—May I point out a mistake in Mr. Sydney Stephenson's very interesting lecture on "Congenital Anomalies of the Eye," in your issue for September 25th? On p. 331 he says:—"I note that the latest book on Diseases of the Eye, by Mr. J. Herbert Parsons, contains the caution not to diagnose pseudo-neuritis 'unless at least 2 D of swelling can be demonstrated.'" If he will refer again to the quotation, he will find that the actual words are:—"*Papillitis* should not be diagnosed unless at least 2 D of swelling can be demonstrated"—exactly the opposite of the deduction which he has drawn. The sentence would doubtless have been less ambiguous and more accurate if I had said that "Papillitis, in the absence of other definite signs, such as hæmorrhages, exudates, etc., should not . . ." I quite agree with Mr. Stephenson in thinking that there is probably never abnormal swelling of the disc in pseudo-neuritis.

I am, Sir, yours truly,
J. HERBERT PARSONS.

27, Wimpole Street, Cavendish Square, W.,
September 26th, 1907.

"THE INTRODUCTORIES."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is to be wondered what most of your readers thought of the Introductories. These effusions certainly were not very cheerful in their tone, that is, encouraging to the young freshmen. Dr. Allchin warned his hearers against the London University. Dr. Ewart certainly took the view that the life of a general practitioner is a miserable one, and in any case a man without means had better keep clear of doctoring, so far as making a living out of practice could be relied on. The other lectures were more or less special, except Dr. Osler's, and he soared into the regions of sentiment and high morality. One subject might have been dealt with, but it was carefully avoided, and that is the influence of unlimited hospital treatment upon the great body of general practitioners, and the extent to which they have suffered. This, of course, is a subject the hospital man dare not deal with, and it would be well if it were boldly considered by the readers of your journal and by the great body of general practitioners throughout the country.

Yours truly,
A REFORMER.

THE NOTIFICATION OF BIRTHS BILL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—I have not the leisure to deal with Dr. McWalter's article in any detail which appears in your last issue, nor do I really think it worth while. I do not believe that medical men will subscribe to the ideas contained in the words as I have heard them expressed, "let the poor little devils die." But I would point out that the mere title of the article ("The Government's Scheme to Promote the Unqualified Practice of Medicine") is at once a libel on the promoters of the Act, an untruth, and an appeal to vulgar passions. It is a libel on the promoters of the Act because they were single-minded in their object; *one thing only* they had in view, namely, to save the lives of helpless babies who are being slain in appalling numbers year by year in this country by the inertia and apathy of the responsible governments, central and local, of the country. The title is an untruth on the face of it. It is ridiculous because it is so obviously untrue. It is just as difficult to point out how it is untrue as it is to give an algebraical demonstration that two and two make four. And it is an appeal to vulgar passions because it ignores the highest and best traditions of our profession, while appealing speciously and meretriciously to self interests.

The Government's Act arises from and follows the lines of the Huddersfield Act, which originated with me. I, therefore, am able to speak with some authority. I trust that it is hardly necessary for me, a medical man, to assure my fellow medical men that I have no desire, and never have had the least desire, to promote the unqualified practice of medicine. In Huddersfield the working of the Act cannot possibly promote the unqualified practice of medicine, because it is worked by two duly qualified and legally registered medical women, *as I have stated in Dr. McWalter's presence.*

Faithfully yours,
J. Moore,
Medical Officer of Health.

OBITUARY.

DR. ARTHUR C. HUDSON, J.P.

We regret to have to record the death of Dr. Arthur Hudson, who died at his residence, near Avoca, in co. Wicklow, at the age of 71. Dr. Hudson acted as medical officer in Avoca for 48 years, and was said to be the oldest dispensary medical officer in Ireland. He was well-known throughout Wicklow, and for the last twenty years was a regular attendant at the local Petty Sessions in his capacity of Justice of the Peace.

REVIEWS OF BOOKS.

BUCHANAN'S MANUAL OF ANATOMY. (a)

Some months ago, when reviewing the first volume of this manual, we were struck by the success with which the author, Professor Buchanan, had combined a systematic and practical Anatomy in one text-book of convenient size. In it the student, when dissecting the extremities, can refer to the description and figures of the bones in the part of the work devoted to osteology. At the same time he has a guide to the method and procedure of dissection following the description of each completed part, and can acquire a sound knowledge of the subject without referring to any other book. The advantages of this arrangement in the manual will at once recommend itself to the teacher as well as the student.

In Volume II., now before us, we find the same admirable plan of treatment of the subject is employed. The reader is given every facility to grasp not only the gross anatomical details but also at the same time can make himself familiar with the developmental history and the histology of the organ which he meets with. The structure of each viscus is fully described. For instance, in the kidney, the relative position, size, shape, lining, epithelium and lumen of the uriniferous tubules are clearly dealt with, and the minute details of the blood supply are given. The present Volume II. is nearly twice the size of Volume I. About the first 300 pages are devoted to the abdomen, 64 of which deal with the structure and development of the abdominal and pelvic viscera. The next 200 pages treat of the thorax. The development of the heart and great blood vessels, and the fœtal circulation, are described at considerable length. The anatomy of the head and neck, the nervous system, the nose, eye, and ear occupy the next 500 pages. An Appendix contains the Bâle nomenclature and a glossary. The latter particularly will be appreciated by the beginner.

Vol. II. is particularly well illustrated (363 figures). Many of these are coloured, especially in the section dealing with the nervous system, where the various nerve tracts are picked out in different tints. The illustrations and diagrams of the microscopic sections leave nothing to be desired. There are also numerous figures devoted to embryology. The only regret we have in regard to this manual is that Professor Buchanan has not included a brief general account of the development of the embryo to aid the student in elucidating particular details.

In conclusion, the many obvious merits of Buchanan's work will rapidly ensure its becoming one of the most popular text-books of the dissecting-room. In it the examination requirements of the student are kept constantly in view, and the subject of human anatomy is made interesting, clear and comprehensive.

TREATMENT OF HIP DISEASE. (a)

This monograph is based upon the author's large experience in the treatment of hip joint disease. He follows very closely the methods advocated long ago by Thomas, but greatly improved on by the author himself. After defining what is meant by hip disease and referring to its pathology, the writer goes on to speak of rest in the treatment of the inflamed joint. Rest is to be obtained by the use of a Thomas's splint. He then specifies in detail the apparatus required for measuring in an ordinary typical case. His method is an improvement on Thomas's, and gives a certainty of fitting the splint to the patient with far greater accuracy and celerity. The directions given are so minute and explicit that anyone can readily understand and carry them out.

The method of making the required splint is next given, and the apparatus required for fitting the splint is fully described and illustrated. The results obtained by the author have been uniformly successful, and certainly his suggestions are excellent in theory. Having referred to the treatment of ordinary and recent cases with flexion and little or no lateral or rotatory displacement, the writer then goes on to speak of the treatment of some complications and sequelæ, especially of cases of old-standing with great deformity. Those cases, he says, in which the limb is fixed in extreme flexion can be reduced by treating them with a double Thomas's splint, made in the same way as a single one with two upright stems, set parallel and at a distance of one inch more than the distance between the tip of the right and the left posterior superior spines.

Prophylactic and drug treatment is also referred to, as well as the operative forms of interference which may be required in very advanced cases of this disease. Regarding bloodless surgery Bennie says that it is "bad surgery, and is a most dangerous operation. Although this operation has been called bloodless surgery, it is usually a most bloody one, but you do not see the blood; it is effused from the torn structures covered by the skin. It is more likely to aggravate than ameliorate the condition." The work is completed by a suitable account of cases actually treated by the author on the lines laid down by him. We have read this monograph with considerable interest as it bears the evidences of much originality of thought, and shows that the writer knows well his subject. It is a book with which every surgeon should make himself thoroughly familiar.

INTERNATIONAL CLINICS. (a)

Volume I. of this quarterly contains the usual yearly summary of the progress of therapeutics, medicine, and surgery, in addition to a series of clinical lectures on various medical and surgical subjects. The individual papers are 14 in number, and are well selected. Dr. Walsh, of New York, writes a most valuable and practical article on the treatment of functional heart disease; Dr. Warthin writes on "The

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(a) "Manual of Anatomy, Systematic and Practical, including Embryology." By A. M. Buchanan, M.A., M.D., C.M., F.F.P.S.Glasg., Professor of Anatomy in Anderson's College, Glasgow; Examiner in Anatomy for the Triple Qualification of the Scottish Licensing Bodies; Examiner in Anatomy and in Physiology for the Dental Diploma, etc., etc. Vol. II. (completion of work) Abdomen, Thorax, Head and Neck, Nervous System, Organs of Special Sense, and an Appendix containing the Bâle Nomenclature and a Glossary. Pp. xv. and 950. Illustrations 363, mostly original and in several colours. Demy 8vo. London: Baillière, Tindall and Cox, 1907. 12s. 6d. net.

(a) "Rational and Effective Treatment of Hip-Disease." By P. Bruce Bennie, M.A., M.D., B.Sc.(Melb.), Hon. Med. Officer Melbourne Hospital for Sick Children, etc. Founded on Experience of numerous cases in Hospital Practice during 28 years. Compiled by Alex B. Bennie, M.A., M.B.(Melb.). London: Baillière, Tindall and Cox. 1907. Price 5s. net.

(a) "International Clinics." Vols. I. and II. Seventeenth Series. Philadelphia and London; J. B. Lippincott Co. 1907.

Clinical Diagnosis of Enlargement of the Thymus"; Dr. Morton on "Neurotic Affections of the Joints"; and an elaborate article on "Disorders of the Umbilicus" is contributed by Gallant. These, to our mind, are the pick of the lot, but the remaining ones are useful as able clinical expositions of the treatment and diagnosis of many of the every-day conditions encountered in general practice. The chief value, indeed, of this journal depends, we think, on its method of dealing throughout the year with common conditions, and laying before the practitioner succinct and up-to-date accounts of what he is constantly being called upon to treat and diagnose. That its method is appreciated is proved by the place that it continues to occupy in medical journalism.

For several years we have been accustomed to say that the annual summary found in the International Clinics is the most readable and useful of the numerous digests of medical progress that are published. This year's summary bears out that opinion. It occupies a little over 100 pages, and yet a careful perusal of it convinces us that nothing of importance has been omitted. At the same time the writers seem to have made a most careful selection, and to have eliminated the great bulk of useless writing that yearly crowds the journals and wearies the reader. The very brevity of the summary enhances its value, for a mere glance enables one to gain possession of the salient points that have engaged medical thought and investigation throughout the year. As usual, the surgical summary is somewhat better than the medical one, because it is written in a narrative style and does not attempt to summarise all surgery, but only to deal with the more advancing branches of the science. Some parts of this section are well illustrated.

Amongst the papers in Volume II. is an interesting one by Flexner on "Experimental Cerebro-Spinal Meningitis," in which he summarises the results of his experiments as published elsewhere. He points out that in periods of from 14 hours up to two or three days after injection by lumbar puncture of cultures of the diplococcus intracellularis into the spinal canal of monkeys, an inflammatory reaction is produced which resembles the condition found in epidemic cerebrospinal meningitis in man. In most of the monkeys, moreover, the nasal mucosa becomes inflamed, and although the organism has not been cultivated from the nose, still diplococci resembling it have been seen in the polynuclear cells of the nasal exudate. This work seems to foreshadow the possibility of the production of an anti-serum for the disease. Two other interesting pathological papers appear, one an admirable summary of our knowledge concerning the macroscopic and microscopic characters of normal and abnormal bone-marrow; the other a contribution to the pathology of general infection by the gonococcus. In the Gynæcological Section Cuthbert Lockyer writes an instructive article on "Appendicitis in Pregnancy," and gives an account of six cases of his own. Clogg writes on "Perforated Duodenal Ulcer," discussing principally the diagnosis and treatment of this condition, and pointing out its comparative frequency. Numerous other papers of interest to both the specialist and the practitioner are included, but are too numerous for individual mention. Many will welcome the opening paper of the Therapeutical Section. It contains a simple and sufficient statement of the theory and principle of vaccine treatment in infectious diseases.

AUSCULTATION AND PERCUSSION. (*a*)

THE majority of students, it is to be feared, do not make a study of physical signs as elicited by auscultation and percussion, contenting themselves with the more or less perfunctory instruction they receive in the wards and out-patient rooms, so that they fail to grasp the *rationale* of the methods they employ, and, memory failing, their powers of observation are left unnecessarily limited. Yet on their ability to apply and interpret correctly the methods of acoustic investigation depends their skill as diagnosticians in a whole series of grave affections. Carelessness, or want of method, or ignorance may render the observer blind to the most obvious phenomena, to the detriment of his reputation and to his ability as a practitioner of the healing art.

A well-thought-out work like the one before us provides the student—and, if need be, the neo-practitioner—with the means of co-ordinating his knowledge and experience, and enables him to reason out that which he may fail to remember. Of the work itself it is hardly necessary to speak, seeing that it is by this time a standard treatise on the subject, couched in language which, if at times a shade archaic, is unusually choice for a technical work.

The history of the subject, as well as the subject itself, is peculiarly interesting. How signs so obvious could have escaped the keen observation of our professional progenitors must ever remain a matter for surprise; but in all probability they had a better acquaintance with them than we are apt to believe.

The author is well advised to impress his readers with the fact that there are other senses than that of hearing, and that the stethoscope does not exhaust our means of perception or dispense with the necessity or other modes of investigation—in other words, auscultation and percussion do not cover the whole field of clinical exploration.

Admirably printed and neatly bound, the work is one to figure in every medical library. It will well repay attentive study.

THE DIGESTIVE SYSTEM. (*a*)

IT is often said nowadays that the surgeon is leaving little or no field for the pure physician, but a book of this kind tells another tale. At the same time it remains true that much of the diagnosis ends in surgery, and the American translator is careful to point out that many of the diseases included lie on the borderland of medicine and surgery. The present work is of considerable value, inasmuch as it presents in English form a careful and authoritative translation of the well-known work, "Die Deutsche Klinik," issued under the editorial supervision of Dr. Julius Salinger. The list of 21 contributors includes the names of many leading Continental authorities. Among them may be mentioned Rosenheim, Ewald, Hirschfeld, Strauss, Boas, and Statelmann, of Berlin; Neisser and Nothnagel, of Vienna; Hoppe and Seyler, of Kiel; Suanboyle, of Bonn; and Fleiner, of Heidelburg. The section upon gallstones, by Neisser, is particularly full and interesting, and that upon gastric ulcer and gastric hæmorrhage compact and accurate. There are 45 illustrations of good quality. The book has been carefully edited, and Professor Billings may be congratulated on presenting to English readers a book that will be invaluable to all physicians.

ON POLYPUS. (*a*)

THE subject under consideration in this monograph has been much debated and many divergent theories have been advanced, so that a concise work of real value is needed in collecting the views of many different authors and at the same time giving those of the writer. The following theories are worthy of mention:—1. That polypi are true tumours. 2. That polypi are peculiarly modified granulations. 3. That polypi are almost invariably a symptom of suppuration in the accessory sinuses of the nose. 4. That polypi are merely a symptom of disease of the ethmoid bone. 5. That polypi are œdematous hypertrophies of the nasal mucous membrane, the indirect result of certain mechanical changes in the mucous membrane glands. The writer's own theory is stated in the words above under the heading 5, and he sums up his remarks as follows:—

1. Chronic inflammation of the mucous membrane.
2. Dilatation of the glands going on to cystic distension, caused either (*a*) through marked inflammatory infiltration of their ducts produced by septic

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(a) "Auscultation and Percussion." By Samuel Gee, M.D., F.R.C.P. Fifth Edition. London: Hodder and Stoughton. 1907.

(a) "Diseases of the Digestive System." Edited by Julius L. Salinger, M.D. (from the Deutsche Klinik). Translated and edited by Frank Billings, M.D., Professor of Medicine, University of Chicago London: Sydney Appleton. 1907.

(a) Polypus of the Nose." By Eugene S. Yonge, M.D. Manchester Sherratt and Hughes.

discharges, or (*b*) through excessive filling of the gland combined with a partial obstruction to the exit of the gland contents.

3. Œdematous infiltration of the surrounding tissues, resulting from the passage of serum through the capilliary walls, due (*a*) to increased pressure in certain capilliaries, owing to obstruction of the capillaries into which they lead, (*b*) to increased permeability in the capillary walls, the result of inflammation, and (*c*) to the laxity of the surrounding tissues.

4. The formation of folds or projections on the infiltrated mucous membrane.

5. The increase of œdema in certain of the folds, formed in the manner described, combined later with a hyperplasia of the fibrous elements.

6. The formation of flat œdematous structures containing the essential constituents of the nasal mucous membrane (broad based or sessile polypi), or of œdematous structures containing the same constituents but a greater amount of fluid, and perhaps of hyperplastic tissue, and each possessing a base which gradually becomes relatively constricted and stretched, until it constitutes a pedicle. This connects the remainder of the structure—which now, through the influence of gravity and other physical causes, has become a globular swelling (pedunculated polypus)—with the mucous membrane from which it sprang.

The little book adds to our knowledge of the subject and is worthy of careful study.

NEW BOOKS AND NEW EDITIONS.

The following have been received for review since the publication of our last monthly list:—

Sidney Appleton (London).
Minor Medicine: A Treatise on the Nature and Treatment of Common Ailments. By Walter Essex Wynter, M.D., etc. Pp. 275. Price 6s. net.

Bailliere, Tindall and Cox (London).
Bloodstains: Their Detection and the Determination of their Source. By Major W. D. Sutherland, I.M.S. Illustrated. Pp. 167. Price 10s. 6d. net.
Treatment by Hypnotism and Suggestion. By C. Lloyd Tuckey, M.D. Aberdeen. Fifth Edition. Revised and Enlarged. Pp. 418. Price 10s. 6d. net.
Nature's Hygiene and Sanitary Chemistry. By C. T. Kingzett, F.I.C., F.C.S. Fifth Edition. Pp. 527. Price 7s. 6d. net.
Marine Climates in Tuberculosis. By William Ewart, M.D., etc., etc. Pp. 48. Price 1s. net.
Preventable Blindness. By N. Bishop Harman, M.A., M.B. Cantab., F.R.C.S.Eng. Illustrated. Pp. 109. Price 2s. 6d. net.

A. Brown and Sons, Ltd. (London).
Modern Methods for Securing Surgical Asepsis By Edward Harrison, M.A., M.D., etc. Pp. 125.

Browne and Nolan, Ltd. (Dublin).
Health and Habits. A Course of Easy Lessons, with an Introduction. By Sir Christopher Nixon, Bart., A.M., M.B., etc. Pp. 157.

John Bale, Sons and Danielsson, Ltd. (London).
Some of the Clinical Aspects of Pneumonia. By Donald W. C. Hood, C.V.O., M.D., etc. Pp. 117. Price 7s. 6d. net.
Some Successful Prescriptions. By Herbert Hart, M.D. Pp. 17. Price 1s. net.
Light and X-Ray Treatment of Skin Diseases. By Malcolm Morris, F.R.C.S.Edin., and S. Ernest Dore, M.D.Cantab. Illustrated. Pp. 172. Price 5s.
Surgical Applied Anatomy. By Sir Frederick Treves, Bart., G.C.V.O., etc., etc. Fifth Edition, revised by Arthur Keith, M.D., F.R.C.S.. Illustrated. Pp. 640. Price 9s. net.

Cassell and Co., Ltd. (London).
Insanity and Allied Neuroses. By George H. Savage, M.D., F.R.C.P., assisted by E. Goodall, M.D., etc., etc. Illustrated New and Enlarged Edition. Pp. 624. Price 12s. 6d.

J. & A. Churchill (London).
Pathology, General and Special, for Students of Medicine. By R. Tanner Hewlett, M.D., etc. Second Edition. Pp. 585. Price 10s. 6d. net.
A Short Manual for Monthly Nurses. By Charles J. Cullingworth, M.D., F.R.C.P. Sixth Edition, Revised and Enlarged. Pp. 128. Price 1s. 6d. net.
A Manual for Hospital Nurses and Others engaged in Attending the Sick. By Edward J. Domville, L.R.C.P., etc. Ninth Edition. Pp. 152. Price 1s. 6d. net.

Henry Frowde and Hodder and Stoughton (London).
Diseases of the Ear. By Hunter Todd, M.A., M.B., etc., etc. Pp. 317. Price 5s. net.
Diseases of the Nose. By Ernest B. Waggett, M.A., M.B., B.C. Pp. 282. Price 5s. net.
A Manual of Venereal Diseases. By Officers of the R.A.M.C. Pp. 282. Price 5s. net.

Henry Frowde (London).
Travels through France and Italy. By Tobias Smollett. Pp. 352. Price 1s. net.

Henry J. Glaisher (London).
On Acute Pneumonia: Its Signs, Symptoms, and Treatment. By Seymour Taylor, M.D., L.R.C.P. Pp. 64. Price 1s. net.

Humanitarian League (London).
How to Reform our Prison System. By H. J. B. Montgomery. Pp. 20. Price 3d.

William Heinemann (London).
Metabolism and Practical Medicine. By Carl von Noorden. Vol. III., English issue, under the Editorship of J. Walker Hall. Price, in 3 Vols., £2 12s. 6d. net.

J. B. Lippincott Co. (Philadelphia).
International Clinics. A Quarterly Edited by W. T. Longcope, M.D. Vol. III., Seventeenth Series, 1907. Pp. 296.

H. K. Lewis (London).
A System of Radiography, with an Atlas of the Normal. By W. Ironside Bruce, M.D. Pp. 110. Price 15s. net.
Hygiene and Public Health. By Louis C. Parkes, M.D., D.P.H., and Henry R. Kenwood, M.D.Edin., D.P.H.Lond. Third Edition. Illustrated. Pp. 620. Price 10s. 6d. net.

Macmillan and Co., Ltd. (London)
The Technique of Vagino-Peritoneal Operations. By E. Wertheim and T. Micholitsch. Translated into English by Cuthbert Lockyer, M.D., etc., etc. Illustrated. Pp. 323. Price 25s. net.
The Prevention of Infectious Diseases. By John C. M'Vail, M.D., D.P H.Camb., F.R.S.E. Pp. 290. Price 8s. 6d. net.

George Pulman and Sons, Ltd. (London).
Ophthalmia Neonatorium. By Sydney Stephenson, M.B., C.M. Pp. 258. Price 12s. 6d. net.

Young J. Pentland (Edinburgh).
Manual of Practical Anatomy. By D. J. Cunningham, M.D., etc., etc. Two Vols. Fourth Edition. Illustrated. Pp. 1,221. Price 21s. net.
Manual of Bacteriology. By Robert Muir, M.A., M.D., L.R.C.P. Edin., and James Ritchie, M.A., M.D., B.Sc. Fourth Edition. Illustrated. Pp. 605.

The Pharmaceutical Society (London).
The British Pharmaceutical Codex: An Imperial Dispensatory for the use of Medical Practitioners and Pharmacists. Pp. 1,422. Price 12 6d. net.

Sampson Low, Marston and Co., Ltd. (London).
On Stammering, Cleft-Palate Speech, Lisping. By Mrs. Emil Behnke. Pp. 92. Price 1s. net.

Simpkin Marshall, Hamilton, Kent and Co., Ltd. (London).
Self-Synthesis: A Means to Perpetual Life. By Cornwall Round. Third Edition. Pp. 33. Price 1s.

Sisleys Ltd. (London).
The Wife: Her Book. By Haydn Brown, L.R.C.P., etc. Pp. 307. Price 3s. 6d. net.

Smith, Elder and Co. (London).
First Aid to the Injured: Six Ambulance Lectures. By Dr. F. Esmarch. Translated from the German by H.R.H. Princess Christian. Seventh and Enlarged Edition. Illustrated. Pp. 138. Price 2s. net.

The Health Resorts Bureau (London).
Wintering in Rome. By A. G. Welsford, M.D., B.C. Second Edition. Pp. 104. Price 2s. 6d. net.

The Scientific Press, Ltd. (London).
A Text-Book of Mental and Sick Nursing. By Robert Jones, M.D., B.S.Lond., etc., etc., with an Introduction by Sir Wm. J. Collins, M.D. Pp. 222. Price 3s. 6d. net.
Nerve Diseases: For Students commencing Hospital Practice. By L. A. Clutterbuck, M.D., etc. Pp. 269. Price 3s. net.

The Sanitary Publishing Co., Ltd. (London).
The Bacteriological Examination of Disinfectants. By Mr. Partridge, F.I.C., with Preface by Major C. E. P. Fowler, D.P.H., F.R.C.S. Price 2s. 6d. net.

John Wright and Co. (Bristol).
The Re-Education of Co-ordination by Movements, with special reference to Locomotor Ataxy. Accompanied by Mounted Charts for the Movement Exercises. By Arthur G. Dampier-Bennett, M.R.C.S., L.R.C.P. Pp. 15. Price, Book and Chart, 10s. 6d. net.

MEDICAL NEWS IN BRIEF.

London Medical Exhibition.

The third London Medical Exhibition, organised by the "British and Colonial Druggist," was opened on Monday at the Royal Horticultural Hall, Westminster. Compared with last year the exhibition marks a great advance; not only is every inch of space taken up, but the interest upon the part of the medical profession is greater than in the previous two years. Last year close upon 5,000 medical men within a radius of twenty miles from Charing Cross visited the exhibition. Patent and special foods and beverages are in great variety. "Equipoise, Limited," exhibit samples of furniture which are as much sought after by the ordinary person as the invalid. Beds, mattresses, chairs, and other articles are in profusion, among others a replica of a couch which was specially ordered by the Queen, and is now in use at Buckingham Palace. The Hospitals and General Contracts Company have an interesting show of their aseptic furniture. The Aylesbury Dairy Company explain what can be done to ensure pure milk. Parke, Davis, and Co., among many other useful exhibits, have a speciality in the shape of the "Yachtomobile" first aid case. As its name indicates, it is suitable either for yachtsmen or motorists, and contains everything necessary to render first-aid in cases of emergency, accident, or shock either on a yacht or motor-car. Messrs. Hearon, Squire, and Francis have on view many samples of opium. These include Persian, Chinese, and English—the latter being most rare and produced in Lincolnshire. They are shown in the raw condition, and also made up in the form of tabloids, although for the English product it should be said that it is probably the only sample of its kind to be found in this country. The exhibition remains open until Friday.

Sanatorium for Consumptive Children.

THE first British sanatorium for consumptive children was opened on October 4th, at Stannington, by the Duke of Northumberland. The institution is in the care of the Poor Children's Holiday Association, which, managed by Mr. J. H. Watson, of Sidney Grove, Newcastle, is accomplishing a work that is deserving of much praise. The Association was started in the year 1891, by taking some of the little slum-dwellers to the seaside; and now it has a training home for girls, a convalescent home, boys' rescue and labour homes, and innumerable agencies for the betterment of the poor street children. At Stannington there is a convalescent home and a farm colony, and a sanatorium in which consumptive children have every chance of being restored to health. Mr. Watson's projects have good friends, who appreciate the enormous value of his labours; but the Association needs £2,000 to complete the capital cost, and, for the expansion of the farm colony, £1,000 is required for a new field. The sanatorium will require at least £3,000 per annum to carry out its work. Boards of Guardians and other bodies have talked about the provision of sanatoria for consumptives; but, if they would endow beds in such an institution as that at Stannington, they would find the work well done, and save the cost of erecting special buildings. The parents of the children contribute towards their support, where they can. But most of the lads upon the farms are orphans

Sheffield Midwife.

AN inquest was held on October 5th at the Jessop Hospital, Sheffield, relative to the death of a woman who had died from puerperal fever. The deceased woman was the wife of a plumber. The inquest was conducted by the City Coroner. According to the evidence of the husband a midwife, Mrs. Fetch, attended the deceased on Friday, September 20th, and the following five days, but did not visit her on the 26th until fetched. Deceased was then in a very bad state, and on the following day was removed to the Jessop Hospital, suffering from puerperal fever. She died there on October 2nd. It was suggested that the midwife had not treated deceased properly, and that a doctor ought to have been sent for sooner. Elizabeth Fetch, the midwife, said she attended deceased at her confinement, which was a perfectly normal and healthy one. Deceased went on well till Thursday, and on that day witness was fetched. She went, and owing to the condition of her patient, told the husband to fetch the doctor, and he did so. She had never asked him to fetch one before, and he had never asked her to do so. She had, however, advised the deceased to have one the day before.—Coroner: But you said she went on all right up till Thursday. Why did you advise her to have one? Witness: She had pains in her head.—Then she did not go on all right? No, sir.—You advised her to have a doctor the day before? Yes, sir; but she refused. Witness contradicted herself several times whilst being cross-examined by Mr. Coath. Asked as to the number of days a midwife was supposed to attend a patient, she first said seven days in succession and the tenth day, and then ten successive days.—Mr. Coath: Did you ever take the temperature of this woman?—Witness: No.—Do you take the temperatures of your patients?—No; I don't understand the thermometer. Replying to further questions, witness first said she had not received complaints from the medical officer of health as to her treatment of patients, and afterwards admitted she had. She also said she could not remember the name of the disinfectant she was in the habit of using. After evidence had been given as to the cause of death, the jury returned a verdict to the effect that deceased had died from puerperal fever. They also added that they thought there had been considerable neglect on the part of the midwife, and that they did not think she was quite the proper woman to practise.

The Carbolic Co-efficients of Sanitas-Okol.

EXPERIMENTS have been made by Dr. Klein with "Sanitas-Okol" to ascertain its carbolic co-efficient on B. Typhosus (a) under ordinary conditions, *i.e.*, in watery dilutions, and (b) in the presence of organic matter—nutrient broth (beef broth and peptone). The strain of B. Typhosus tested was an active subculture in nutrient broth (24 hours' incubation at 37°C) derived originally from the spleen of a fatal case of enteric fever, several generations removed from the original source. In all instances to 5cc. of the dilutions of Phenol or "Sanitas-Okol" respectively five drops of the broth culture of B. Typhosus were added, and after exposure for the desired time, three loops—same loop being always used—were taken from the medicated fluid, and transferred to sterile nutrient broth in tubes. These were then transferred to an incubator, and kept for three days at 37°C, after which time the result was noted. From the experiments it appears that in the absence of organic matter the carbolic co-efficient of "Sanitas-Okol" is $\frac{1800+1700}{90+85}=20$; in the presence of organic matter it is $\frac{1600+1500}{90+85}=17.7$.

Death under an Anæsthetic.

MR. HENSLOWE WELLINGTON held an inquest on the body of Robert M'Donald, aged 47, a pastrycook, who died in St. Thomas's Hospital after undergoing an operation. Robert Greatorex, brother-in-law of the deceased, complained that the hospital authorities did not notify the relations that an operation was to be performed and that a relapse had followed. Dr. Nightingale, house surgeon at St. Thomas's Hospital, said that the deceased had called at the hospital some days before, and had been informed of the necessity for an operation, and came to the hospital on Monday for that purpose. He was asked to communicate to the relatives the fact that the operation was to be performed on the following day. He promised to do so, but apparently did not. The operation was a difficult one, and ether was the anæsthetic used. It was successfully completed, but later hæmorrhage started from the surgical wounds, and though all that was possible was done, the hæmorrhage continued. It was decided that nothing more could be done for him without an anæsthetic, and the deceased was taken to the operation theatre again. Chloroform was administered, and under its influence deceased stopped breathing. Artificial respiration was resorted to, and Mr. Adams, one of the surgeons, endeavoured to massage the heart, but it was found to be flaccid. In answer to the first witness the doctor said that the case was so urgent that there was no time to communicate with the relatives. Dr. Trevor said that death was due to heart failure due to loss of blood following on the operation. The jury returned a verdict accordingly.

Disputed £100,000 Hospital Bequest.

AN influential committee of ratepayers in Streatham have recently circulated a memorial to the Charity Commissioners with the view of obtaining £100,000 left by the late Mr. Weir to establish a medical institution in Streatham parish. The holders of the money, it is alleged, now propose to hand over practically the whole sum to the Bolingbroke Hospital, which is in the Borough of Battersea. The petition says that Streatham needs the hospital, and that they should not be deprived of the bequest given to them by the late Mr. Weir for the hospital and a properly organised ambulance service.

REUTER'S Agency has received from the chief medical officer of Helsingfors a statement that no cases of Asiatic cholera have occurred in that town. This declaration refers to a Reuter's telegram of September 18th stating that three cases of cholera had occurred at Helsingfors.

Pathology in Bristol.

Before the function at the opening of the winter session at University College, Bristol, when Professor Gotch distributed the prizes, and delivered a stirring address on the University question, Professor Walker Hall gave a demonstration in the Museum of the Royal Infirmary. This was largely attended by medical men from the districts around. At 2.30 p.m. there was a lantern demonstration of microscopical preparations. This was followed at 2.45 p.m. by an account of residual opsonins by Dr. J. H. Munro. Dr. J. J. Lucas related some anomalous cases of tuberculosis—cases which gave practically no clinical symptoms, or gave indications of typhoid, or of pernicious anæmia. Dr. Walker Hall then described some new methods for the mounting of museum specimens, and for the estimation of sugar in urine, and fat in fæces.

Entrance Scholarships at the London Hospitals.

The following announcements were made at the opening of the Winter Session at the London Medical Colleges:—

St. George's Hospital.—The University Entrance Scholarships in Science have been awarded as follows:—R. F. Jones, B.A., Pembroke College, Cambridge, and L. A. Lewis, Edinburgh University, equal, a scholarship of 60 guineas each, and E. W. M. H. Phillips, Jesus College, Oxford, scholarship of 50 guineas.

London Hospital.—Price Scholarship in Science, value £120.—Mr. T. D. Williams. Science Scholarships, value £60.—Mr. N. R. Rawson. Science Scholarships, value £35.—Mr. J. H. Lloyd. Price Scholarship in Anatomy and Physiology.—Mr. G. J. F. Jessel (Univ. of Oxford). Epsom Scholarship (£126).—Mr. E. H. Henson.

Charing Cross Hospital.—The following Entrance Scholarships have been awarded:—The Epsom Scholarship (115 guineas), to Mr. J. E. Ashby; The Huxley Scholarship (55 guineas), to Mr. E. M. Morris. Entrance Scholarships have also been awarded to Mr. A. E. Hallinan (40 guineas), and to Mr. W. Leslie (30 guineas). Universities Scholarships of 72 guineas each have been awarded to Mr. W. R. Thomas and Mr. C. W. Shepherd, both of the London University.

Middlesex Hospital.—The following Entrance Scholarships have been awarded:—Arts Scholarship.—Mr. C. E. Thornton. Science Scholarship.—Mr. W. Butterfield. University Scholarship.—Mr. W. M. Penny. Frere Lucas Scholarship.—Mr. A. L. H. Rackham.

King's College Hospital.—The following Scholarships have been awarded in the Faculty of Medicine:—Medical Entrance University Scholarship (£50).—H. A. Treadgold. Warneford Medical Scholarship (Arts) (£50).—A. S. Wakeley.

The Porthcoming Tuberculosis Exhibition in Ireland.

An inaugural address in connection with this exhibition will be delivered by Professor William Osler, F.R.S., Regius Professor of Medicine in the University of Oxford, in the Theatre of the Royal Dublin Society, Kildare Street, on Friday, October 11th, at 8.30 p.m. The title of the lecture is, "What the Public Can Do in the Fight Against Tuberculosis." Admission will be free.

PASS LISTS.

University of Durham.

At the Convocation held on Saturday, September 28th, 1907, the following degrees were conferred:—

Doctor in Medicine.—Thomas Hartigan, M.B., B.S., Durh.; Frederick William Kemp, M.B., B.S., Durh.; Wharram Henry Lamplough, M.B., B.S., Durh.; Frank Laughton-Smith, M.B., B.S., Durh.; Frederick Robert Henry Laverick, M.B., B.S., Durh.; Morgan Richards, M.B., B.S., Durh.; Ernest Charles Young, M.B., B.S., Durh.

Doctor in Medicine for practitioners of fifteen years' standing.—Henry T. S. Aveline, M.R.C.S., L.R.C.P.; Edgar Beaumont, M.R.C.S., L.R.C.P.; John F. Butler-Hogan, B.A., M.D. (Brux.), L.R.C.P. and S., L.F.P.S.G., D.P.H.; Geoffrey Cross, M.R.C.S., L.R.C.P., L.S.A.; John Cumming, F.R.C.P. and S., E., L.F.P.S.G.; Ludford Cooper, M.R.C.S., L.R.C.P.; John Freeman, M.R.C.S., L.R.C.P.; Arthur Hawkyard, L.R.C.P. and S., E.; John W. D. Hooper, L.R.C.P. and S.; Hedley Hill, M.R.C.S., L.R.C.P.; Llewellyn Lewis, M.R.C.S., L.R.C.P.; William M. Palmer, M.R.C.S., L.R.C.P., L.S.A.; Arthur W. Read, M.R.C.S., L.R.C.P., F.S.A.; Hugh J. Roberts, M.R.C.S., L.S.A.; Henry F. Steele, M.R.C.S., L.R.C.P., L.S.A.; John F. Woodyatt, M.R.C.S., L.R.C.P.; Richard M. West, M.R.C.S., L.R.C.P.; George C. W. Wright, M.R.C.S., L.R.C.P.

Bachelor in Medicine (M.B.).—George E. P. Davis, L.R.C.P. and S., L.F.P.S.G.; William H. Edgar; George R. Ellis; Charles W. Greene; Herbert F. Joynt; Edward P. Joynt; Charles G. Kemp, M.R.C.S., L.R.C.P.; Herbert Max Levinson; Hector G. G. Mackenzie, M.A.; Stanley D. Metcalfe; Elizabeth N. Niel; Roland W. Pearson, M.R.C.S., L.R.C.P.; James W. Smith; George Walker; Lionel L. Westrope, L.R.C.P. and S., L.F.P.S.G.; Frank Whitby; Cuthbert R. Wilkins.

Bachelor in Surgery (B.S.).—George Edward Peckett Davis, L.R.C.P. and S., L.F.P.S.G.; William H. Edgar; George R. Ellis; Charles W. Greene; Herbert F. Joynt; Edward P. Joynt; Charles G. Kemp, M.R.C.S., L.R.C.P.; Herbert Max Levinson; Stanley D. Metcalfe; Elizabeth N. Niel; James W. Smith; George Walker; Frank Whitby; Cuthbert R. Wilkins.

Bachelor in Hygiene (B.Hy.).—George Denholm, M.B., B.S., Durh.; George P. Harlan, M.D., Ch.B., Glas.

And the following received the Diploma in Public Health (D.P.H.).—George Denholm, M.B., B.S., Durh.; Albert G. W. Pearson, M.B., B.S., Durh.

Guy's Hospital Medical School.

The following Entrance Scholarships and Certificates have been awarded:—Senior Science Scholarships for University Students (£50): J. G. Saner, Caius College, Cambridge.

Junior Science Scholarships (£150): J. F. Mackenzie, Preliminary Scientific (M.B.) Class; (£60) R. D. Passey, Preliminary Scientific (M.B.) Class.

Certificates.—T. J. Bennett, Preliminary Scientific (M.B.) Class; G. E. Genge-Andrews, Preliminary Scientific (M.B.) Class; S. Keith, Preliminary Scientific (M.B.) Class.

Entrance Scholarships in Arts.—(£100) C. S. L. Roberts, Cheltenham College; (£25) G. D. Eccles, Plymouth Technical School and (£25) G. F. Romer, Malvern College (equal).

The Royal University of Ireland.—The Third Examination in Medicine.

The following candidates have passed the above-mentioned examination:—

Upper Pass.—*Albert V. Craig, *William Dickey, James A. Hanrahan, *Richard W. G. Hingston, David Horgan, *John C. Houston, *Edward G. Kennedy, Ernest W. Kirwan, *Patrick J. Lydon, B.A., *Michael G. O'Malley, David A. Rice, Thomas Scanlan, William S. R. Steven, Alfred M. Thomson, Michael Twohig. (Those marked with an asterisk had the liberty of presenting themselves for the further examination for Honours, which commenced on Monday morning, October 7th.)

Pass.—David R. Acheson, William J. Ashby, Percy M. J. Brett, Daniel Broderick, Francis S. Carson, Victor L. Connolly, William Doolin, Joseph S. Doyle, William P. Dunne, B.A., Patrick Hayes, Jeremiah Holland, Joshua Keyms, B.A., Samuel K. McKee, William Magner, Thomas P. Magnier, George E. A. Mitchell, Thomas J. S. Moffett, James M. O'Reilly, Alexander Patton, B.A., Samuel P. Rea, William Riddell, John Spence, Hill W. White, Robert Young.

Queen's College, Cork.

We are officially informed that the King has been pleased to approve of the appointment of Bertram Coghill Alan Windle, Esq., M.D., F.R.S., the President of Queen's College, Cork, to the Professorship of Anatomy in the said College, to hold such Professorship concurrently with his office of President, and of the appointment of David Thomas Barry, Esq., M.D., to be Professor of Physiology in the said College.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Early Diagnosis of Pulmonary Tuberculosis.—Hammans and Wolman have analysed the records of 1,745 cases of pulmonary tuberculosis met with at the Phipps Dispensary (*Johns Hopkins Hospital Bulletin*, August, 1907). Out of this number they find that 150 cases may be classed as early, and every one of these presented either slight changes in the percussion note, modified breath sounds, or râles. When all three signs were present, the diagnosis was regarded as complete by physical signs alone, but in 61 cases further aid in diagnosis had to be obtained either by examination of the sputum, by the tuberculin test, or by observing the further course of the disease. Out of the 61 cases, a change in the percussion note was detected in 47 per cent.; breath sounds were modified in 61 per cent.; and râles were heard in 53 per cent. In 24 of the cases tubercle bacilli were found in the sputum, and in 24 other cases that did not show bacilli in the sputum a positive tuberculin reaction was obtained. The symptom for which many patients presented themselves was hæmoptysis occurring after a variable period of coughing, while in 16 per cent. of the cases hæmoptysis was the earliest symptom. As regards the tuberculin test more value is apparently to be placed on a negative than on a positive reaction, except when the positive reaction is borne out by the history, the symptoms presented, and the physical signs. M.

The Opsonic Index for Streptococci in Scarlatina.—Banks has investigated the opsonic index for streptococci in scarlatina with the object of attempting to determine what part streptococci play in the complications of that malady (*Journal of Path. and Bact.*, October, 1907, p. 113). He employed Wright's method of determining the index, and made use of four strains of streptococci, one of which was the strepcoccus pyogenes. The index was taken on different days of the disease, and during the period of convalescence. He formulates his conclusions as follows:—(1) In the early febrile period the index is low: it reaches normal with the decline of symptoms, but falls again during the second and third weeks. It again reaches normal during the fourth and fifth weeks. (2) In fatal cases with severe angina, the power is markedly subnormal. (3) The index is low during the presence of such complications as albuminuria, severe nephritis, and secondary adenitis. (4) A persistently low index during nephritis is an unfavourable sign. Fourteen cases in all were investigated, of which five ran a fairly normal uncomplicated course. M.

Microbic Cyanosis.—Gibson again draws attention to the condition known as microbic cyanosis (*The Quarterly Journal of Medicine*, Vol. I., No. 1, p. 29). Five years ago Stokvis first called attention to the causation of cyanosis by intestinal disturbance, and suggested that some toxin absorbed from the alimentary tract led to the formation of methæmoglobin. Later, other cases were recorded, and in 1906 Gibson reported a case in which there was marked cyanosis accompanying chronic diarrhœa. Examination of the blood in this case showed the presence of methæmoglobin, and some nitrites, and the bacillus coli communis was obtained readily in cultures made from the blood on agar. Nitrites also were found in the saliva, but only in small quantities in the fæces. After treatment of the case for several months with intestinal antiseptics, a marked improvement took place. The cyanosis became much less, the general symptoms ameliorated, and the blood no longer contained organisms. The methæmoglobin also disappeared, but traces of nitrites were still found. The author believes that the condition must be regarded as due to a chronic bacillæmia in which the bacillus coli communis is the pathogenic organism at work. M.

The Parathyroid Glands.—Harnett has examined the parathyroid glands found at 42 consecutive autopsies (*Trans. Path. Soc. London*, Vol. 58, Part II., 1907). His anatomical and histological investigations, so far as they have gone, seem to allow of the following deductions, which are of interest at the present time, when so much importance has been attached to these glands. (1) The activity of the parathyroid increases as age advances. (2) The parathyroid normally forms a secretion indistinguishable microscopically from that formed in the thyroid. In diseases such as myxœdema and goitre this secretion is formed in greater quantity. There is as yet no proof that the parathyroid forms any other secretion besides colloid. (3) There is no histological evidence in favour of the view that the gland has a function of its own essential to life, nor are there any grounds for supposing it to be the organ specially affected in any diseases. M.

Chronic Valvular Disease of the Heart.—Carr (*Practitioner*, September, 1907), in a paper on this subject, discusses the difficulty in diagnosis in cases of adherent pericardium. In chronic mitral valve disease the diagnosis is often greatly facilitated by the symptoms of failure of compensation, but many cases in children progress to a fatal termination without the marked development of the so-called "back-pressure symptoms." In Carr's experience many such cases have also an adherent pericardium, and it is to this more than to the valvular lesion that the symptoms present are due. The ordinary signs of this condition, as enumerated in books, apply mainly, if not exclusively, to adhesions between the pericardium and the chest wall, or mediastino-pericarditis. Carr believes that in children with mitral, but no evidence of aortic disease, and a heart so dilated as to give rise to well-marked precordial bulging, there is very considerable probability that the pericardial sac is obliterated, even though no history of pericarditis can be obtained. The presence of subcutaneous rheumatic nodules, he also believes, almost invariably indicates the existence of active heart mischief. K.

Balsam of Peru in Scabies.—Baker (*R.A.M.C.*, *Journ.*, September, 1907) gives the result of this treatment, which has been carried out in sixty cases at the Military Hospital, Arbour Hill, Dublin. The details of the treatment were given in the *Journal* in January and February of this year by Major Porter. In none of the sixty cases has there been any relapse, nor has there been a case of albuminuria though the urine has been examined at regular intervals after the application of the balsam. Baker considers the preliminary hot bath, efficiently carried out, as an essential, but differs from Major Porter in preferring the pure balsam, while the latter used a mixture of glycerine and balsam in the proportion of one to three. The results in the Arbour Hill Hospital have been very satisfactory, and several patients have been discharged from hospital cured twenty-four hours after admission. The drug is expensive, but the short duration of the treatment more than counterbalances this. K.

Cancer of the Stomach.—Packe (*The Med. Chronicle*, July, 1907) brings forward statistics illustrative of this subject based on the post-mortem records of St. George's Hospital during a period of ten years—1890-1900. During this time there were 227 autopsies performed on cases of cancer of the internal organs, and of these cases sixty, or 26.5 per cent., were cases of cancer of the stomach. Cases of cancer of the œsophagus came next in frequency, and formed 15.9 per cent of the total, while cancer of the colon gave a percentage of 15, and cancer of the rectum 7.9 per cent. From an investigation of these returns Packe draws the following conclusions:—That primary cancer arises more frequently in the stomach than in any other internal organ. That though cancer in general is on the increase, yet the increase of cancer of the stomach is greater proportionately. That males are more frequently the subjects of cancer of the stomach than females, the proportion being 1.85 to 1. The most fatal decade of life for cancer of the stomach is from fifty to sixty years. In this period 32.01 per cent. of the cases occurred. That cancer may follow as a late result of gastric ulcer. That 55 per cent. of the growths occur at the pyloric end of the stomach. That perforation of the stomach occurs most frequently when the growth is on the anterior wall. That cylindrical-celled cancer shows a preference for the pyloric end of the stomach, while the largest number of cases of spheroidal-celled carcinoma were of the form invading the entire stomach. That the histological nature of the growth has no effect on the incidence of metastases or of ulceration. That the œsophagus is the chief seat of primary cancer growth in secondary cancer of the stomach, the pancreas following next in order of frequency. K.

The Starch and Opium Enema.—Ryley (*R.A.M.C. Journ.*, September, 1907) states that on several occasions he has seen severe tympanites follow the administration of this form of enema; in one case the tympanites was so severe that it caused cardiac embarrassment and death. He believes that this condition is the result of two causes. (1) The opium causes a paralysis of the rectum which is consequently unable to expel flatus; (2) the fermentation of the starch causes a rapid evolution of gas, which fills the bowel. Ryley has found by experiment that when starch is incubated at the body temperature, mixed with a little fæces, that large quantities of carbon dioxide gas are formed. K.

The Cerebral Localisation of Aphasia, and its Classification on an Anatomical Basis.—Dana (*New York Med. Record*, August, 1907), by means of an ingenious form of graphic representation, describes the typical symptoms of the four chief types of aphasia:—(1) The frontal or fronto-capsular, characterised by aphemia, with retained ability to read, write and understand; (2) parieto-occipital aphasia, characterised by alexia, with ability to speak, write, and understand, associated with hemianopsia; (3) temporal or temporo-parietal aphasia, characterised by anoesia, some mind deafness, paraphasia, much agraphia and alexia, without hemiplegia, but with some astereognosis, anæsthesia, and ataxia; and (4) fronto-lenticular aphasia, the common mixed aphasia, characterised by aphemia, with much agraphia, alexia, mind deafness, and deafness with hemiplegia. The chart by which each case is represented includes 22 functions tested and recorded as "normal," "slightly impaired," "seriously impaired," or "absent." In conclusion, a short discussion of each of the more important of these functions is given, with the anatomical locations and significance of impairment. D.

Diet in Kidney Affections.—Hanssen (*Nord. Med. Ark.*, Stockholm) tabulates the findings in regard to the metabolism of a number of persons on different diets. They show that the amount of solids eliminated in the urine is as large on a strict milk diet as on a meat diet. The demands on the kidneys are thus as high on a milk diet as when meat is ingested. Fats and carbohydrates, on the contrary, made far less demands on the kidneys, the latter less than the fats. He confirms the reliability of the "variability test" to determine the functional capacity of the kidneys. His conclusions are that a predominant or exclusive diet of carbohydrates with a little fat is indicated in all cases in which the functional capacity of the kidneys is reduced to or below the limits of normal sufficiency. Milk and meat, providing the same amount of calories, cause elimination through the kidneys of about the same amount of molecules, while materially smaller amounts of solid elements are eliminated through the kidneys on a diet of carbohydrates with a little fat. He regards a maximal specific gravity of 1.014, or 1.015 under the "variability test" of the urine as an indication that the limits of sufficiency of the kidneys have been reached, and that meat and milk should be restricted. If the specific gravity does not rise higher than 1.013 or 1.014, or there are signs of retention, then meat and milk should be entirely, or almost entirely, suppressed. In case of uremia, nothing should be allowed but gruels with milk sugar. This takes the place of milk in regard to diuretic action. D.

Physical Therapy of Headache.—Riedel (*Berlin. Klin. Woch.*, 1907) discusses the treatment of headache from the standpoint of physical therapy. In cases of hyperemic headache he advises absolute rest, with cold applications to the head, and hot applications or friction to the lower extremities. Colonic flushings are also said to be of value, as well as active purgation. If the headache is of the paroxysmal variety, cold applications to the head, for a minute at a time, and walking in water at a temperature of from 8° to 10° C. for ten minutes at a time, act almost specifically. Naegel's manual head-stretching is also warmly recommended. For headaches of anæmic origin the head is placed low and the scalp is massaged. Hot compresses applied to the forehead or the nape of the neck, and application of warmed cloths around the neck, are also valuable. Massage is the most efficient treatment in cases of rheumatic headache. The hot air douche and warm applications of various kinds may also be used. The same treatment is indicated in cases of neuralgic headache. The author places much reliance on the intelligent use of massage as a means of relieving such headaches, but emphasises the fact that the physician himself must carry out the treatment, and that it can not be applied by rule of thumb, as it were. D.

New Infection of Persons with Inherited and Acquired Syphilis.—(*Dermat. Zeit. Berlin*, 1907.) Stern's patient was a man of 28, who had a primary syphilitic sore, with numerous pale spirochetes, differing in no respect from an ordinary primary infection with syphilis, and yet the man presented the unmistakable signs of inherited syphilis, or syphilis acquired in early infancy, with tertiary phenomena. This makes the ninth case on record, Stern remarks, in which persons with syphilis in infancy, either inherited or acquired during the first weeks of life, acquired a fresh infection in early adult life. He summarises 80 cases of re-infection in cases of acquired syphilis, and draws the conclusion that the re-infection in many instances is conclusive testimony to the complete cure of the primary infection. He emphasises the necessity for teaching patients this, so that those who have had syphilis in the past may guard against contracting it anew instead of considering themselves immune. His experience also indicates that a strong resistant organism may pass through syphilis with the organs comparatively intact and escape the dreaded consequences. The pessimistic idea that a person once infected is always infected, and immune to future infection, should be combated, he declares, for numerous and obvious reasons. D.

Dublin Sanatorium for Consumptives.

The *Dublin Gazette* of last week contains the confirmation of the Local Government Board Order respecting the Dublin Joint Hospital District, under which the Lord Mayor, Aldermen, and Burgesses of Dublin have constituted a Joint Board for the provision, maintenance, and management of a hospital to be used for a sanatorium for consumptives in the following sanitary districts—County Borough of Dublin, Balrothery Rural District, Celbridge No. 2 District, North Dublin District, South Dublin District, and Dalkey Urban District. The Board will consist of 31 members, and all expenses incurred by the Board are to be defrayed out of a common fund, into which shall be paid sums received from the component authorities in respect of the cost of maintenance of patients and the sums recovered by the Joint Board from or repaid to the Joint Board by or for patients.

Royal College of Physicians in Ireland.

The annual dinner of the College will be held on Saturday, October 19th, instead of on St. Luke's Day, which this year falls on Friday.

NOTICES TO CORRESPONDENTS, &c.

☛ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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THE MEDICAL DIRECTORY FOR 1908.

To the Editor of The Medical Press and Circular.

Sir,—The amalgamation of various London Medical Societies under the title of the Royal Society of Medicine necessitates a great many alterations in the forthcoming issue of *The Medical Directory*, and we shall feel obliged if all Fellows of the Society, or Members of Sections, will kindly give us at once the necessary information. We may say that we have now decided to abbreviate the entries to the following:—Fell. Roy. Soc. Med., or Mem. —— Sect. Roy. Soc. Med.

Many gentlemen, in making their returns, have overlooked the fact that several of the old societies have ceased to be. Of course, we have to delete such entries for the future.—Your obedient servants,

The Editors.

Dr M. P. K.—Owing to unusual pressure on our space during the past few weeks, there has been a little delay in the insertion of papers. We hope to have space for your communication in our next.

A facetious correspondent has sent us the following:—

SELF-MEDICATION.

One curse of the nation is self-medication,
As now we're beginning to find;
While *symptoms* are treated by doses repeated,
The *cause*, of course, never opined.
Then they find the mistake, for the pain or the ache
Is not quite so easily cured,
And they give up the game, and with sadness exclaim:
No! no! it must all be endured!
For everyone gibes at the man who prescribes;
The chemist will suit just as well.
He will always suggest what he thinks is the best,
But the name of no doctor he'll tell.
Christian Science they try, but they find bye and bye
It's not of the slightest avail;
Unless they're neurotic, it's all "Tommy-rotic,"
And they're certain to find it to fail. A. D.

Mr. J. W. Williams.—The estimated population of London, excluding the outer ring, is 4,758,218; that of Glasgow, 847,584; Dublin, 390,691; Belfast, 370,183; Edinburgh, 345,747. If your inquiry relates to Greater London for comparison, the official number is 7,217,941.

Meetings of the Societies, Lectures, &c

Wednesday, October 9th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. P. J. Freyer: Clinique. (Surgical.) 5.15. p.m.: Lecture:—Dr. G. H. Savage: The Psychoses of the Aged.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Thursday, October 10th.

Royal Society of Medicine (Obstetrical and Gynæcological Section) (30 Hanover Square, W.).—7.45 p.m.: Specimens will be shown by Dr. Eden and others. Short communication:—Dr. A. Routh: A Case of Cæsarean Hysterectomy for Traumatic Atresia of Vagina, the Patient having previously been Successfully Operated upon for Vesico-vaginal Fistula. Paper:—Prof. W. E. Dixon and Dr. F. E. Taylor: On the Physiological Action of the Placenta.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. H. Evans: Cysts and Cystic Conditions of the Neck.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson), X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Throat Operations (Mr. Carson). Lecture:—Dr. Forsyth: Goitre.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Essentials in the Study of Dermatology.

Friday, October 11th.

Royal Society of Medicine (Clinical Section) (20 Hanover Square, W.).—8.30 p.m.: Inaugural Address: The President (Sir Thomas Barlow). Exhibition of Cases. The patients will be in attendance at 8 p.m.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Dr. St. Clair Thomson: Clinique. (Throat.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Vacancies.

Birmingham, City of, Asylum, Rubery Hill, near Birmingham.—Assistant Medical Officer. Salary, £150 per annum, with apartments, board, etc. Applications to Medical Superintendent.

St. James's Gate Brewery, Dublin.—Resident Assistant Medical Officer. Salary, £150 per annum, with furnished apartments. Applications to the Chief Medical Officer, St. James's Gate.

The Earlswood Asylum, Redhill.—Junior Assistant Medical Officer. Salary, £130 per annum, with board, lodging, and washing. Applications to the Secretary at the Offices of the Asylum, 36, King William Street, London Bridge, E.C.

Manchester, University of.—Senior Demonstrator in Physiology. Salary, £150 per annum. Applications to the Registrar.

Bradford Poor-Law Union.—Resident Assistant Medical Officer. Salary, £100 per annum, with rations, apartments, and washing. Applications to George M. Crowther, Clerk to the Guardians, Union Offices, 22 Manor Row, Bradford.

Brompton Hospital Sanatorium.—Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to the Secretary, Brompton Hospital, London.

Three Counties (Gloucester, Somerset, and Wilts) Sanatorium for Consumptives, Winsley, near Bath.—Resident Medical Officer. Salary, £200 per annum. Applications to the Secretary, at the Sanatorium.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary, £160 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

Valkenberg Asylum, near Cape Town.—Assistant Medical Officer. Salary, £250 per annum, free board, washing and lodging. Applications to Agent-General for the Cape of Good Hope, 100 Victoria Street, London.

Albany General Hospital, Grahamstown.—House Surgeon. Salary, £200 per annum, with board, furnished quarters, and laundry. Applications to the School Registrar, St. Bartholomew's Hospital, E.C.

Edinburgh District Asylum, Bangour Village.—Second Assistant Physician. Salary, £120 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent, Bangour Village, Uphall.

West Sussex County Asylum and Graylingwell Mental Hospital, Chichester.—Junior Assistant Medical Officer. Salary, £150 per annum, with furnished apartments, board, attendance, etc. Applications to the Medical Superintendent.

Births.

Barlee.—On Oct. 1st, at 6, Coates Crescent, Edinburgh, the wife of Dr. H. J. W. Barlee, of a son.

Mansell.—On Sept. 28th, at Crofton, West Hill, Hastings, the wife of H. R. Mansell, M.R.C.S., of a daughter.

Marriages.

Atkins—Highton.—On Oct. 5, at Christ Church, Brondesbury, Frederick Durnford Atkins, M.B., B.S., M.R.C.S., L.R.C.P., son of Frederick T. Atkins, Chelston Manor, Cockington, Torquay, to Edith Agnes, second daughter of the late Rev. Edward Highton, M.A., Rector of Tarrant-Keynston.

Badgerow—Oxley.—On Oct. 5th, at St. George's Church, Hanover Square, London, George W. Badgerow, M.B., M.R.C.S. (Eng.), only son of A. H. Badgerow, J.P., of Toronto, to Maud, eldest daughter of Herbert Oxley, Esq., of 3, Hans Crescent, London.

Garrett—Hall.—On Oct. 2nd, at the Parish Church, Hampstead, Raymond Reynolds Garrett, M.R.C.S., L.R.C.P., fifth son of Lewis B. Garrett, of Maida Vale, London, to Josephine Bell, daughter of the late Thomas Hall, of Newcastle-on-Tyne.

Ginner—Smith.—On Oct. 1st, at Holy Trinity Church, Southport, Ernest Wightman Ginner, Esq., M.D., of Cannes, France, elder son of the late I. B. Ginner, Esq., of Cannes, to Eiley, younger daughter of the late J. E. Smith, M.D., of Grimsby and Southport.

Motherwell—Parsons.—On Oct. 5th, at St. Peter's, Bayswater, Gavin Black Motherwell, jun., Airdrie, N.B., to Margaret, only daughter of Sidney Parsons, M.R.C.S., and L.S.A., 78, Kensington Park Road, London.

Deaths.

Gallagher.—At Duala, German West Africa, of fever, Dr. John Gallagher, late Bombay Medical Service, aged 60.

Jotham.—On Oct 2nd, Helen, eldest daughter of the late George William Jotham, M.R.C.S., L.S.A., in her 69th year.

Stolterfoth.—On Oct. 4th, at Grey Friars, Chester, Henry Stolterfoth, M.D., J.P., aged 71 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, OCT. 16, 1907. No. 16

NOTES AND COMMENTS.

Socialism and Medicine.

WITH the anti-Socialist campaign that is at present engaging the energies of certain politicians, we have, of course, nothing to do; but we may, perhaps, pause to ask why it is that the Socialists who, we understand, advocate the universal brotherhood of man, seem to take an almost morbid delight in offending every party and class in the country. If the world, socialistically organised, is to be a paradise such as we look forward to in the millennium, it will, we take it, not depend for its success on the prevalence of the spirit of bitterness that animates some present-day Socialists. The medical profession seems to be a particularly red rag to the Socialists, and in their organs we frequently find, either in the editorial or correspondence columns, some attack, veiled or overt, on medical men. Considering that quite a number of medical men are Socialists, and that the profession itself is the only one in the land that shares its acquired possessions freely with those in need, the attitude of the Socialist spokesman is an extraordinary one. Perhaps no more striking confirmation of these assertions could be obtained than by an extract from the Socialist children's catechism which has been sent us. It runs as follows—

"Have poor people objections to the present hospitals?"

"Yes; they are afraid that the doctors and students will make experiments on them."

"Why do doctors make experiments on poor people?"

"Because it gives them experience, which they sell to the rich."

"Do students practice on the rich?"

"No; the rich will not tolerate it."

The Young Idea.

Now, if malignant and spiteful lies of this kind are taught to the rising generation of Socialists, we may expect it to mature in time into a race even less regardful of truth and shame than the people who poison its young mind with atrocious statements such as these. The meanest and most sordid motives are here imputed to the doctors, and they can have but the effect their authors desire—namely, to disgust and sicken every honourable man of the Socialists' propaganda and methods in this country. We cannot but feel, however, that such shameful lies would be disowned by the philosophical Socialists, who believe in Socialism as a creed, and set themselves to practice its doctrines of self-abnegation and sharing with the poor, and who are not Socialists for the sake of self-advertisement or self-interest. At the present day the beauty of Socialistic precepts seem about as much overlaid with undesirable personalities as the beauty of Christianity was in certain mediæval periods.

Notification of Births Act.

THERE are several authorities now debating the advisability of adopting the Notification of Births Act, and one or two which have already done so. We are glad to see that the aspect of the Act which is so offensive to medical men is being represented in most quarters, and last week, at Battersea, Mr. Burns' own constituency, where the adoption of the Act was regarded as a foregone conclusion, the matter has been adjourned for consideration, in consequence of strong medical protest. It is greatly to be hoped that medical men all over the country will make a powerful effort to impress their views on the local authority. It must be made plain that there is no hostility to the principle of the Act, or any desire to obstruct or hinder the health authorities, but quite the reverse. But it should be represented that the Act, as passed, is most offensive to the profession, in that they are bound under penalty to see that their patients perform their civic duties, and that the character of half-spy and half-policeman is not one which practitioners care to undertake. There is no reason why medical men should be dragged into the measure at all, and if this aspect of the Act is presented to local authorities, and they can be persuaded to represent it to the Local Government Board, it would be a very simple matter for a one-clause Bill to be passed through Parliament next session to rectify this injustice.

Melbourne Hospital Staff Election.

A CORRESPONDENT in Melbourne has sent us a description from the *Melbourne Argus* of the proceedings that took place at the election of the honorary medical staff at the Melbourne Hospital in August. It is difficult for anyone living in the antiquated atmosphere of the old country to understand how anything so derogatory to professional dignity could take place in any country at the present day. Apparently the whole medical and surgical staff was chosen, the election being by the subscribers, anyone paying a guinea having a right to vote. According to the *Argus*, the scene resembled "a third-rate race meeting or a Tammany convention." The street was crowded with cabs, carriages and motors, bringing voters to the poll, and the hall where the polling took place and the approaches were crammed with professional canvassers, who are on hire for any election that may be going on. As people arrived they were button-holed, cajoled, and persuaded. Cards were thrust into their hands, and yells of "Don't forget Dr. Dash," or "Give one vote to Dr. Blank," made the place hideous. The candidates were rushing voters to the tables, and a smart man could, it would seem, get a supporter from someone else by dint of a little tact. Nor were the ordinary amenities of a fair election observed, for hundreds of ballot-papers were taken out of the room to be marked, and faggot-votes were created by a special department, in which people came and paid a sovereign—whose sovereign nobody cared—and received a vote on the spot. At any rate, nearly three hundred votes were thus created on the last day.

And Some Reflections. Now how far responsibility for such undignified proceedings rests with the management and constitution of the hospital, and how far with the medical men concerned, of course we are unable to say, and we can only grieve that the fame and honour of medicine should be so besmirched. Considering that honorary hospital posts are supposed, in theory at least, to represent a form of service to people so poor as not to be able to pay for medical attendance, it can only stultify the profession in the eyes of the public if such appointments are sought with all the vulgarity of public suffrage. On the other hand, if it is desired by the hospital to secure the services of the most competent physicians and surgeons, we can only say that the method adopted seemed so designed to cater for the least scrupulous, whatever its results may be in practice.

Vivisection Horror. It is not a little instructive to notice the way the newspapers are dealing with the latest volume of evidence before the Royal Commission on Vivisection. Naturally, the more responsible journals give fairly impartial summaries; but a shorter and more picturesque way adopted by others is to drag out a certain passage or incident which seems to support the views of the particular journal, and to paste it large upon its sheet. Thus the *Morning Leader* flashed out last week with an article headed, "Vivisection Horror. Official Denials of Obvious Facts." Now anti-vivisection, anti-vaccination, and anti-medical generally as the *Morning Leader* is, it is certainly not edited without a sense of humour, and if ever the weakness of the anti-vivisection case was exposed, it is by the fact that this "Horror" was the worst thing that could be dished up. In reality, it was the most hollow farce. The Hon. Stephen Coleridge was written to this summer by an undergraduate at Keble College, Oxford, who said that his rooms were opposite the University Museum, and "nearly every day he was harassed by the piercing yells of a dog in agony." The gentleman in question visited the museum, and ascertained from an "official" that vivisection was carried on there. The letter contained the usual vituperative remarks about scientists, and several gentlemen endorsed the complaint. Mr. Coleridge promptly wrote to Professor Gotch, who replied that no vivisection experiments on dogs had been carried out in the laboratory during the present year.

And Four Puppies. "But," slyly added the Professor, "four puppies were born and kept in the adjoining yard, and the shrill yelps of these animals when at play were presumably the sounds heard by your correspondent." Needless to say, the young gentleman who had made himself so supremely ridiculous was much annoyed at being so neatly and completely bowled out, and he descended to abuse and wild hearsay, calling Professor Gotch a liar and so on. Really the *Morning Leader* must be careful, for what would be left of it but yellowness were it not for its humour, and what can be said for the humour of a journal which calls the delighted yells of four puppies at play a "vivisection horror?"

LEADING ARTICLE.

THE ALLEGED CRISIS IN THE MEDICAL PROFESSION.

First of all, let us ask if a crisis is actually at hand in the medical profession. The answer depends a good deal upon what is meant by the term "crisis." If it asserts that the profession, as a whole, is likely to come to an untimely end in the near future, and to wither away and die for sheer lack of sustenance, then the notion may be at once dismissed. If, on the other hand, it indicates that the medical practitioners of the United Kingdom are to-day faced with scanty and diminishing incomes, with increased living expenses, with a lessened field of work, and with the handicap of competing hospital and quack practice, there is truth enough in these things and they undoubtedly point to a crisis. The phrase, used in the latter sense, simply expresses the plight of a long-suffering profession, whose good nature has been abused, and whose rights have been violated on all sides. The crisis is realised more or less in the higher ranks of the profession, among the consultant and the specialist. Its more serious effects, however, are experienced by the general practitioners, for no profession, however high and noble its ideals, can hope to survive on any but a sound economic basis.

Truth to say, the public are themselves greatly to blame. As a general statement they do not pay their medical attendants for more than two-thirds or three-quarters of the service rendered. Obviously that means a good deal in the case of small incomes, where appearances have to be kept up, and where expenses are heavy. Read in that light, the authoritative estimate of the average income of the British practitioner, at £200 or £250 a year, reveals a crisis in itself. It speaks volumes for the high standard of honour which the public know to expect from medical men that so poor a profession should contain so few black sheep. After all said and done it must be confessed that medical men have themselves to thank for much of the mischief. They have no powerful organisation like the lawyers, to maintain an adequate scale of fees and to punish promptly all illegal practice. The General Medical Council enforces an iron discipline upon the qualified medical man, but, unlike the Incorporated Law Society, takes no heed of the inroads of the unqualified practitioner. In the latter particular the powers both of the Council and of the profession are grievously curtailed by defective medical acts. While these acts carefully control the education and test the knowledge of the medical man, they nevertheless permit any charlatan without the shred of a pretence to medical training to practice any branch of medicine so long as he does not style himself a doctor. The reform of the medical acts, indeed, lies at the root of a great part of the evils. The State, however, so far from seeking to advance the status and prosperity of the deserving class concerned, seldom fails to seize any opportunity of exacting from it further gratuitous service, as, for instance, in the Notificaton of Births Act recently passed through Parliament. In doing this the powers that be have simply kept to the precedent whereby the death certificate, another important document, is also exacted without fee or reward. It may safely be assumed that no Government, however strong, would venture to impose a responsible duty of that kind upon the legal profession without fixing an adequate fee in return.

As medicine becomes more and more an exact science, and as disease after disease is banished from our midst, it follows that the field of medical practice must be correspondingly lessened. What a vast sum of money the medical profession has been (quite legitimately) deprived of during the past ten years by the reduction of small-pox almost to vanishing point! What is true of small-pox will one day be true of many other diseases. Nevertheless, so far as one can see, there will always be need of a certain number of medical men to act surgically and to advise the individual how to preserve his health as well as to keep up public prevention at the highest possible pitch of perfection.

It has been suggested that the whole medical service should be brought under the control of the State. The suggestion seems Utopian, at any rate in our present stage of civilisation. So far the State has left the medical man, after a costly and arduous training, to sink or swim without further attempt at his protection. Is the State likely to alter its ways by adopting the *rôle* of a master? Not many years ago, by a stroke of its legislative pen, whole armies of fever-stricken patients were taken away from the care of private practitioners and lodged in public infectious hospitals. The resulting benefit to the community has been, in part at any rate, at the cost of the medical profession. Has the State ever shown any wish to make good that loss to the medical profession, even by way of defending their elementary right against unqualified persons?

It is clearly a matter of supreme importance to the community to maintain a service of competent and flourishing medical practitioners. As things go they are threatened with the atrophy of an indispensable professional class. The crisis is a real one and the remedy to a great extent in the hands of the community.

"THE GRIP OF THE SPECIALIST."

Under the sensational title of "The Grip of the Specialist," one of the young lions of the *Nation*, which is our old friend the *Speaker* rejuvenated, has been roaring at the growing tyranny of the medical profession, and reverberations of the roar have found their way into the leading columns of the *Tribune*. Both these excellent papers profess to shiver at the power which is passing into the hands of medical men, and we fear, although they are careful not to commit themselves too definitely, at the way in which it is used. "Everywhere among the educated public we encounter signs of disquietude, distrust, sometimes of vocable revolt, against the dominion of the doctor, and the elaborate professional and business apparatus that has grown up around him." Thus runs the "vocable revolt" of the *Nation*, and that of the *Tribune* is like unto it. Well, it is always an excellent thing to have a little outside advice, and we must not be offended so long as it is for our souls' good, but we confess that this "vocable revolt" on the part of the public has till now not reached our ears, though there has been some vocability and even revolt on the part of the medical profession at the way they have been treated by the public, and in our opinion there should be a great deal more. The *Nation* tells us that most sane laymen "tremble at the power of the new priesthood," and that now that the Church has lost influence its mystical authority has devolved upon the medical profession. "The mantle of Elijah has fallen on Elisha." Now, without disrespect to the Church we may perhaps be so bold as to say that it seems to us an excellent thing that the medical part of its work has been handed over to a *cadre* organised and trained *ad hoc*, and that the Church has been left free to pursue its spiritual functions, in which it has always been considerably more successful than it has in dabbling in medicine. But knowledge is power, and whereas the medical man has no more authority than any other citizen maliciously to wound or officially to overawe His Majesty's lieges, yet he is granted a power to inflict wounds on and prescribe dangerous drugs for those people who voluntarily place themselves in his hands. A medical qualification is absolutely valueless except as a passport to practice, and practice is, or should be, entirely a matter of personal confidence between doctor and patient. In other words, a doctor has no power except over those people who voluntarily place themselves in his power, and they can remove themselves from his care whenever they like. Where the "grip of the doctor" comes in, we fail to see; anyone who continues in the "grip" of a doctor he does not believe in is a fool. The specialist is a particularly dreadful fellow, according to the *Nation*. "The absolute confidence with which a specialist of repute will impose a long, painful, and expensive treatment, which other specialists of no less repute condemn, bewilders and amazes those new to the annals of modern medicine." But his amazement apparently does not prevent the layman going to the specialist, even though "when he (the layman) is taken ill it becomes a matter of chance whether he is forced to undergo a dangerous operation, is put on novel and hazardous diet, is sentenced to two months' close confinement, or to a long term of distant exile," and yet he dares not refuse the treatment or take further advice! Really the specialist's grip seems to us remarkably weak, and assuming for the sake of the argument his saturnine character, he seems only likely to maintain his grasp on those foolish people who are too weak to enter into "vocable revolt." Indeed, we should not feel ourselves such villains after all that the *Nation* says, if it said but that, but we consider it utterly unworthy of a journal with traditions of the *Speaker* behind it to descend to general innuendo with regard to medical men receiving secret commissions from hotel-keepers, chemists, and members of similar callings. We should think it beneath our own dignity, if merely out of spite, and without a tittle of evidence, we suggested that the editor of the *Nation* was bribed by politicians to support their views; but he on his part does not hesitate to throw out an equally unworthy charge against the medical profession. To bolster up a weak case with a vindictive charge is not the type of journalism we expected from the *Nation*, to whose success in the enterprise before it we have looked forward with pleasure.

CURRENT TOPICS.

Anæsthetic Fatalities in London Hospitals.

THE question of death under anæsthetics is one in which both the medical profession and the public are deeply interested. In spite of many individual and collective investigations there is still much to be learnt regarding the scientific side of these unhappy accidents. As we have already pointed out in the columns of the MEDICAL PRESS AND CIRCULAR, it would be an important logical step in the formal analysis of the situation were one to secure accurate comparative statistics in full detail from the various London hospitals. In order to avoid any invidious criticism the returns would be made under letter or number, without the publication of any names. It seems perfectly obvious that figures thus presented would indicate useful lines of further investigation. Another rich field of data lies in the Coroner's Court. We are glad to see that Dr. Waldo, the Coroner for the City of London, is making an exhaustive inquiry into the anæsthetic deaths that take place within his districts, which include the great hospitals of Guy's and St. Bartholomew's. In another column we publish a short summary of such an inquest held by him on the body of a woman who died on the 3rd of October at Guy's Hospital, while undergoing an operation for exophthalmic goitre. Chloroform was administered by the house surgeon, who stated he had given anæsthetics in some 98 cases, and who admitted he knew the special anæsthetic risks of that particular operation. He assumed full responsibility, but later the surgeon said he himself was partly responsible for the administration. The Coroner naturally inquired why in a non-urgent case of admitted difficulty the services of one of the eight staff anæsthetists attached to the Hospital were not called into requisition. The authorities of Guy's may have some satisfactory explanation to offer, but meanwhile the public will probably be inclined to agree with the jury that the present system is to blame. The matter is in various ways one that requires careful handling. We all know that medical men must acquire a knowledge of anæsthetics, but there is no apparent reason why in a large hospital juniors should not be kept under constant supervision. What is the use of staff anæsthetists if they are not required to attend cases of special difficulty, either at administration or at supervision of administration?

Unvaccinated Teachers

THE educational sea appears to be doomed to manifold storms. In the London County Council a fresh disturbance has arisen over a recent resolution framed in the interests of preventive medicine. It was resolved that in the event of smallpox arising in a school or college any unvaccinated teacher refusing to be vaccinated within twenty-four hours will not only be excluded, but will not be paid any salary during the period of absence. It seems clear that on moral grounds the teacher, however much he may be entitled personally to reject vaccination, must yield to the views of the majority when the welfare of others is concerned. While it may be conceded that a school authority is acting on the lines of commonsense prudence in excluding an unvaccinated teacher from school during a smallpox outbreak, we fail to see why such an unprotected person was ever allowed to assume a position of the kind. Indeed, it almost seems that to allow unvaccinated teachers to mingle with State school children is to permit an open violation of laws that have been formally adopted by the legislature, with enormous resulting benefit to the community. The unvaccinated school teacher is typical of the restless band of anti-vaccinationists ever on the look out for some loophole of evasion to a most salutary law.

Butchers and Tuberculous Meat.

THE war against consumption can hardly be waged seriously until steps are taken to exclude tuberculous meat and milk from the national commissariat. Chester, at any rate, is taking the matter vigorously in hand, so far as cattle are concerned. The Corporation of that ancient city have been forced in self-defence to bring pressure on the farmers attending Chester fairs, and to demand from the latter a guarantee against tuberculosis in their cattle. The butchers suggest that the farmer shall insure approved beasts, and that where a butcher has a guaranteed carcase seized he shall be recouped to the extent of two-thirds of the price. This proposal has naturally caused a good deal of commotion amongst the farmers, who belong, as a rule, to a somewhat conservative class. They have held, so it is reported, a crowded meeting, at which strong opinions were expressed that compensation should be paid for condemned carcases out of public money. Few political economists would question the principle involved in granting State compensation for the compulsory destruction of tuberculous cattle. On no other basis would a law to that effect be enforced in the United Kingdom. For a sum costing far less, say, than the late Boer war the country could be freed several times over from tuberculous cattle. Some day this inevitable reform will be forced upon the community.

Research Scholarships on Effects of Alcohol.

FOR several generations a kind of scientific or semi-scientific warfare has been waged over the question of alcohol and its effects upon the human body. *Mirabile dictu* the mass of observations, chemical, biological, clinical, and pathological have not yet been reduced to established and scientific generalisations. Truth to say, the medical mind is chaotic as regards the desirability of retaining alcohol as a beverage. On the other hand, most practitioners will endorse the view that alcohol has a distinct value as a therapeutic agent in sickness, and perhaps also as a stimulant in various depressed physiological states. The recent issue of a manifesto and a counter-manifesto signed by some of the most distinguished names in the medical world, however, marks the sharp divergence of the twentieth century on so important an everyday matter as the consumption of alcohol by the community. The National Temperance League has taken the practical step of founding research scholarships for the purpose of investigating the effects of alcohol. It is to be hoped, however, that the task will be entrusted to absoluely impartial scientific investigators, for there is hardly any sociological matter in which the individual judgment is apt to be more biassed by personal views than that of the proper place of alcohol in the world's economy.

College Athletics.

It is a matter of some regret that in most American colleges and universities athletics are overdone. One of the consequences is that there is a strong public feeling hostile to the practice of athletics, and all such exercises, good and bad, are likely to come into disrepute. We are assuming that some athletics are good, and in this country, for the present at any rate, there are not many to question the assumption. The severe discipline undergone by all who really engage in arduous sport must have moral and physical effects of some value. As a matter of fact, the lives of distinguished athletes are, in an insurance sense, "good," and old "Blues" are not only long-lived but healthy. On the other hand, there is considerable risk in the overtraining that seems to be prevalent among athletes in America. It is said that in that country it is impossible, or nearly so, for a student who wishes to gain scholastic distinctions to devote any time to games. This is certainly very different from the state of affairs in our own Universities, and is very far from what ought to exist. It is certainly true also that the abnormal development of muscle to which injudicious training gives rise is by no means an advantage to the human economy, and it is probable that deleterious effects on the blood-vessels also result. Under the circumstances, it is not matter for wonder that some of the professional journals in America have declared a crusade against athletics at schools and colleges, and some of them suggest that athletic games should be put on the same level as gambling, and strictly forbidden.

The Tuberculosis Exhibition in Dublin.

The Executive Committee of the Tuberculosis Exhibition, which was opened in Dublin last Saturday by His Excellency the Lord-Lieutenant of Ireland, are to be congratulated on their initiative in starting the first exhibition of the kind in the United Kingdom. In no part of the kingdom, indeed, is such a lesson so much needed, for in none is the damage wrought by tuberculosis so great, and in none are the public health authorities so lax in their attention to their first duty. The committee is further to be congratulated on having brought together a series of exhibits which cannot fail to give instruction of value, and on the great public interest which their enterprise has aroused. It is seldom, indeed, that one sees such a large and intelligent audience assembled to discuss any matter affecting public health as that which listened to Professor Osler's lecture in the Royal Dublin Society's premises on Friday evening. The practical advice given to him as to the means to be adopted by the public in fighting against tuberculosis cannot fail to bear fruit. The exhibition itself is, as may be seen from out description of it elsewhere, admirably adapted to interest and instruct the public in matters relating to the prevalence of the disease, and to the methods to be adopted to prevent its spread. Statistical, pathological, therapeutic and sanitary exhibits help to show the members of the public bodies and others charged with responsibility for the public health both the magnitude of the evil and how it may be met with success. Popular lectures and demonstrations serve to explain those matters which are not obvious in themselves. It is intended that, when the exhibition has spent a few weeks in Dublin, it should be taken on tour to the various large towns of the country, and that every means be taken to bring its lessons home to the public.

PERSONAL.

Mr. T. J. P. Hartigan will give a course of lectures on Dermatology at the Hospital for Diseases of the Skin, Blackfriars, on Mondays, Wednesdays, and Saturdays at 5 p.m., from October 9th to December 21st.

Dr. Hector W. G. Mackenzie will open a discussion at the Medical Section of the Royal Society of Medicine on Tuesday, October 22nd, at 5.30 p.m. The subject will be, "The Complications in Sequelæ of Pneumonia, and the Possibilities of Treatment by Serum or Vaccine."

Dr. MacLennan, of Thurso, was the recipient of a handsome present on the occasion of his leaving Thurso, where he has been in practice eight years.

Professor Francis Gotch distributed the prizes at the opening of the Faculty of Medicine at University College, Bristol.

Mr. Justice Walton will give the inaugural address of the Medico-Legal Society's first meeting at 22, Albemarle Street, W., on October 29th, at 8.15. Dr. W. H. Willcox will give a demonstration on Wounds Produced by Firearms at the same meeting.

Professor Simeon Snell will give the first post-graduate lecture at the Royal Eye Hospital, Southwark, to-night (Wednesday), at 7 p.m. His subject will be "Injuries and Wounds of the Eye, Eyelids, and Orbit."

Dr. Alexander Macphail, Professor of Anatomy at St. Mungo's College, Glasgow, was given a complimentary dinner and a handsome presentation by a hundred medical men of that town on the occasion of his relinquishing his appointment for that of Lecturer in Anatomy at Charing Cross Hospital, London.

Dr. Laurence Humphry has been appointed Assessor for the year to the Regius Professor of Physic at Cambridge.

Dr. E. R. S. Lipscomb has been presented with a valuable clock on resigning his appointment, held for twenty years, of Medical Officer to the Starcross Branch of the Rational Association Friendly Society.

Dr. H. F. Devis has been made the recipient of a presentation by the employees of the Great Western Railway at Bristol on resigning the post of Honorary Lecturer on First Aid, after fourteen years' work.

Colonel F. J. Lambkin, R.A.M.C., of the Royal Army Medical College Staff, has been deputed by the Secretary of State for the Colonies to carry out special investigations in the Uganda Protectorate.

Mr. Girling Ball, F.R.C.S., has been elected to the Luther Holden Research Scholarship in Surgery for the year 1907-8.

Dr. Orr, of Tayport, has been elected President of the Fifeshire Medical Association for the coming year, in succession to Dr. Balfour Graham, of Leven.

The inaugural address of the session at the Meath Hospital and County Dublin Infirmary was delivered on October 9th by Dr. James Craig, M.D., Physician to the Hospital.

Dr. David Rice, Senior Assistant Medical Officer of the Staffordshire County Asylum, has been appointed Medical Superintendent of Norwich City.

A Clinical Lecture
ON
ENLARGEMENTS OF THE LIVER. (*a*)

By W. HALE WHITE,

Senior Physician to and Lecturer on Medicine at Guy's Hospital.

Gentlemen,—It came into my mind, when asked to deliver this lecture, that we are in our daily life constantly examining the liver, and therefore it might not be amiss if this afternoon we discussed some points connected with its enlargements, especially the difficulties of appreciating and interpreting variations in its size.

Sometimes we are, I think, inclined to forget that in infants and children the liver is relatively larger than in adults, for while in an adult it is about 1-36th of the body weight, at birth it is only between 1-18th and 1-24th. More than once I have known forgetfuness of this lead to mistakes.

Feeling the liver is of much greater clinical use than percussing the area of hepatic dulness, and as a rule it is easiest to feel the edge of the liver just outside the edge of the right rectus. It is true that in the epigastric angle a small portion of the anterior surface of the left lobe comes in contact with the anterior abdominal wall, but often in actual practice this cannot be felt, for nowhere in the abdomen is it more difficult to feel through the wall than in that part formed by the upper quarter of the two recti, for they are thick muscles, and cannot easily be pushed in from their attachments. On the other hand, this may be the only portion of the liver which can be felt, especially if the ribs are thrown forwards and outwards, as in emphysema.

With regard to organs resting against the liver, the fact that its superior surface has on it a slight depression made by the heart is of little clinical importance, for the diaphragm here is so firm and dense that enlargements of the heart hardly ever directly affect the liver; but the close contact of the left lobe of the liver to the lesser curvature of the stomach, and the contact of the pylorus with the quadrate lobe are of great importance, for not only may ulcers and malignant disease of the stomach grow directly into the liver, but tumours of the stomach may sometimes be dragged up and down during respiration, moving with the liver. For the same reason tumours of the hepatic flexure of the colon or of the kidney may move up and down with respiration, as both these organs are adherent to the under surface of the liver.

Many mistakes have been made from forgetfulness of the fact that a tongue-like projection of the right lobe may protrude from its lower right-hand part. This projection, which is called Riedel's lobe, is often associated with disease of the gall bladder, such as gall-stones, or with tight-lacing, and is commoner in women than men; but it may be found in quite young children; so in some cases, at least, it is a congenital abnormality. The connection between a Riedel's lobe and the liver may be only peritoneal, in which case the lobe may easily be confounded with a floating kidney, especially as there may be a band of resonance between it and the liver. A Riedel's lobe may also be confused with almost any abdominal tumour which occurs on the right side of the abdomen. It rarely gives rise to any symptoms, but is often associated with those of gall-stones—why, we do not know. However, a Riedel's lobe is not at all common, but still the lower and outer part of the right lobe of the liver may be very difficult to tell from a right kidney. I feel sure that this difficulty is much more frequent than text-books would lead us to expect.

Many conditions unconnected with the liver cause an apparent alteration of it, and these conditions have often been the cause of mistakes in diagnosis. When the body is wasted and the tissues are lax, the organ may drop down. I will allude to the condition of wandering liver presently, but, quite apart from this, a general weakness of tissues may lead to dropping of the liver. I have had a strange experience this summer, for on two occasions I have known men thought to have cancer of their liver because it seemed enlarged, and they were very wasted, but the wasting was really due to diabetes, and the liver, although a little enlarged, appeared to be much larger than it really was, for it had dropped considerably. Again, when the liver is enlarged and heavy, it is very liable to fall, and it is no uncommon thing to find that the nutmeg liver of the patient with heart disease, who sits propped up in bed, has dropped two inches, for it may be ascertained, even when there is no emphysema, that the upper limit of the hepatic dulness is lower than it should be, and then, of course, the liver is not as large as mere palpation appears to indicate. Again, alterations in the chest lead to depression of the liver, which may be erroneously thought to be enlarged. Thus, in an extreme case of fibrosis of the lungs, with adherent pleura, I have seen the sucking-in of the ribs on inspiration lead to depression of the liver down to the umbilicus. Again, deformities of the chest due to rickets or curvature of the spine may lead to great depression of the liver. With a very large collection of fluid in the right pleural cavity, the liver may be depressed, but I would suggest that there is much misconception on this point, and that depression of the liver by a collection of pleural fluid is much rarer than is commonly believed. The reason is that, owing to its firm attachments, it is not easy to depress the diaphragm, and the fluid more readily makes room for itself by compressing the lung and pushing over the heart. When, however, there is a large amount of pus in the right pleura, the liver will be more readily depressed than by simple fluid, for in the case of an empyæma the diaphragm itself becomes inflamed and so weakened, and, even with pleurisy, if it affects the diaphragm, the liver may appear to be a little depressed, for if the pleural surface of the diaphragm be inflamed, the pain of moving the muscle prevents the patient doing so; hence the diaphragm is kept in a constant position of inspiration, and the liver being also constantly in the position of inspiration, appears depressed. This may be the explanation of the statement that the liver is depressed in pneumonia of the right lung.

Talking of pleural leads our minds to pericardial effusion. We are usually told that extreme pericardial effusion will depress the liver, but I think this must be very rare. It certainly is in my experience, and I should expect it to be so, for the pressure would have to act through the very firm central part of the diaphragm. A subdiaphragmatic abscess being below the diaphragm will, however, depress the liver considerably.

We may get into difficulties when the liver has been altered by tight lacing. Often quite a slight degree will, as is well known, lead to the formation of furrows on the liver evidently corresponding to the ribs, but furrows which obviously cannot correspond to the ribs are sometimes thought to do so. They are too vertical for furrows due to ribs, and it has been suggested that they are due to the fact that the liver is compressed laterally during inspiration, and expands again during expiration. Tight lacing may, by local constriction, lead to the formation of such a deep furrow that part of the liver during life is apparently separated from the rest. Recently a man was in the hospital with what was thought by many who saw him to be an elongated tumour lying transversely in the

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(*a*) Being the Opening Address delivered before the North-East London Clinical Society on October 3rd, 1907, at the first meeting of the Session, 1907-1908.

abdomen, but it was nothing but the lower part of the liver nearly cut off from the rest by the pressure of a belt he had worn. The furrow may be so deep that the blood supply of the isolated portion of the liver is impaired; then I have seen fatty change confined to such a part.

The effects of corsets upon the liver as a whole will depend upon the position of the pressure. Most commonly the liver is forced down, flattened and elongated from above downwards. The liver thus forms an apron covering much more of the abdominal viscera than is natural, but some of the intestines may get in front of it. The pressure often leads to a transverse depression across the right hand lower part of the right lobe, so that a more or less detached piece of the liver lies over the right kidney, and is, indeed, an artificial Riedel's lobe, and may lead to the same difficulties of diagnosis. When the pressure is by lacing applied lower down, the liver is pushed up into the chest, and is thickened in its vertical diameter.

Various abdominal conditions alter the position of the liver, and the ease with which its size may be ascertained. Contrary to what might be expected from some teaching, it is, I think, quite rare for any enlargement of the liver to lead to upward extension of the hepatic dulness. This is what we should expect, for the mere weight of the enlarged liver will lead to its falling, and as the resistance of the intestines and abdominal walls is much less than that of the diaphragm, it will grow in the direction of least resistance. Enlargement of the hepatic dulness upwards is best seen when some local disease of the liver directly implicates the diaphragm. Thus an abscess of the liver will grow from the upper surface of the liver, soften the diaphragm, and extend upwards; a hydatid will do the same. From this it follows that when there is an extension upwards of hepatic dulness, it is a local extension, forming a dome-shaped addition to the hepatic dulness. Very large collections of ascitic fluid, or very large abdominal tumours, may push the liver up, and so lead to an increase of hepatic dulness upwards; but this is not common, for such tumours or collections of fluid will more readily cause protrusion of the anterior abdominal walls and compression of the intestines.

When working at the bedside, it is most important to remember that there are three moderately common tumours which lie transversely in the abdomen, and so may be thought to be the lower margin of an enlarged liver. They are a stomach affected with malignant disease, especially when the growth infiltrates much of the greater curvature; malignant disease of or impaction of fæces in the transverse colon; and the great omentum thickened and puckered up towards the transverse colon by some form of chronic peritonitis. Any of these tumours may move up and down with respiration, for they are all directly or indirectly attached to the liver, but their movement is not usually so extensive as that of the liver should be. And a band of resonance may sometimes be detected between the liver and the tumour, or the edge of the liver may be felt above it. Enlargements of the pylorus and thickening in connection with a gastric or duodenal ulcer may be difficult to tell from an enlarged gall-bladder, not only from their position, but because they may move up and down with respiration.

The hepatic dulness may be altered by gas. Thus it may be almost obliterated by the descent of an emphysematous lung, and a slight lowering of the upper margin of the hepatic dulness from this cause is quite common. Another result of emphysema is that the lower ribs stand out so far, in a position of extreme inspiration, that they bring the upper part of the abdominal wall so far forward that it is often quite impossible to feel the liver. This state of affairs is by no means uncommon.

When, as in perforative peritonitis, free gas collects in the abdominal cavity, it usually gets in front of the liver, and so may diminish the hepatic dulness; but this sign is, in my experience, more often absent than present in perforative peritonitis. On the other hand, obliteration of the lower part of the hepatic dulness by no means always indicates that there is free gas in the peritoneal cavity, for coils of intestine, or the colon, may get between the liver and the anterior abdominal wall. This is of no clinical significance.

As we have been talking about conditions which push the liver out of place, we are naturally led to a consideration of a wandering or movable liver. To this state of affairs the term hepatoptosis is often applied, and by it we mean a liver which, being unduly displaceable, leaves its normal position and forms an abdominal tumour. It is particularly to be noticed that a liver displaced by a tumour or any other cause is not a wandering liver, for it is just as fixed, only in an abnormal position, as a normal liver; but a wandering liver can be easily moved about. Further, as clearness of thought is dependent upon clearness of expression, we ought, I would suggest, never to use the unfortunate phrase "partial hepatoptosis." It has been applied to a Riedel's lobe or to pieces of liver more or less cut off from the rest of the organ by wearing a band or belt. It should be discarded, for it has nothing to do with hepatoptosis proper; but it is worth remembering that sometimes the part of the liver cut off from the rest by wearing a band has been thought to be the whole liver, and has been considered to be an example of hepatoptosis. Another phrase that should be avoided is floating liver. The liver, suspended by its various ligaments, always floats in the abdomen, and therefore the phrase, floating liver, does not designate an abnormality. Yet another bad term is that of total hepatoptosis. Strictly speaking, that would mean that the liver could be moved about in the abdomen to an indefinite extent, which is absurd. So much attention has of late years been directed to Glénard's disease that there is an impression, I think, that a wandering liver is commoner than it really is. It is, I would suggest, very rare. In a well-marked case, owing to absence of support, the organ drops and rotates on a transverse axis, so that the upper diaphragmatic surface comes in contact with the abdominal wall, and the anterior surface points a little downwards. The result of this is that a large amount of liver comes in contact with the anterior abdominal wall. Such a liver may be felt to be a large flattened tumour extending down to or below the umbilicus. It forms a visible protrusion, moves up and down with respiration, can usually be pushed back into its normal position when the patient lies down; indeed, sometimes on lying down it goes back of its own accord, only to fall again when the patient stands up. It is movable laterally, and can with the hands be rotated round a vertical axis. If it has dropped far there is hardly any hepatic dulness in the chest, and the hand may even be passed up between the ribs and the liver. In such a case there is a depression at the upper part of the abdomen, and this is very characteristic. We need not spend more time on hepatoptosis, as it is so rare.

We now pass on to consider enlargements of the liver proper, for hitherto we have only considered conditions which appear to make the liver large, but do not really do so.

When we pass our hand over the abdomen and feel an enlarged liver, the first thing that naturally arrests our attention is whether the enlargement is uniform. Now the diseases which enlarge the liver, but not uniformly, are hydatid, abscess, growth and syphilis. The enlargement of both hydatid and abscess—if the abscess is of the usual variety—is local in one part of the liver, the rest being healthy; but with growth and syphilis the enlargement is usually of the greater part of the liver, although it is very often irregular. Hydatid and abscess are in this country rare, but, unfortunately, malignant disease is not, for searching our hospital records shows that, of all persons in whom at death malignant disease is found, about 50 per cent. have secondary deposits in their liver, and no organ is more often the seat of secondary deposits. Therefore it will not be amiss if we first consider some points about the enlargement due to cancer of the liver. In the first place, cancer causes the liver to be heavier than any other disease of it. I have known the liver weigh 19 lbs., and even heavier weights have been recorded. It is quite true, as the books tell us, that the nodule of growth may be umbilicated, but it is very rare for this umbilication to be tangible through the abdominal wall, but when it is, the fact is, I would suggest absolutely diagnostic of cancer. So, too, is a very sudden increase in size of a lump in the liver. I have known one to considerably increase in size in a single night. This must, I think, always mean that the swelling is malignant, for the sudden increase must indicate hæmorrhage into the tumour, and the only tumours of the liver into which hæmorrhage can occur are those of a malignant nature. If the growth is breaking down, it may feel soft, and give an obscure sense of fluctuation; but this is rare, and is more in favour of abscess or gumma than growth. If the liver has considerably increased in size in a week, it is strongly suggestive of growth, for the liver never enlarges so quickly as when affected by a rapidly growing growth. The age of the patient is of importance, for cancer of the liver is almost unknown at an earlier age than 20. Before, in a doubtful case, passing an opinion that a liver is not cancerous, the patient should be made to take a deep breath, for it is just possible that a tumour under the ribs may thus be felt. Of course, if most of the cancerous masses are at the upper part of the liver, it may be impossible to feel them during life, but failure to do this is rarely due to the fact that the cancerous masses are in the centre of the liver, for in the post-mortem room we hardly ever find cancerous nodules in the interior of the liver if none are to be seen on the exterior. But we must by no means go away with the impression that lumps can always be felt during life if the patient has malignant disease of his liver. As pointed out, they may be in the upper part or they may be on the under surface, or they may be too small to be felt, or the abdominal wall may be too rigid, or, again, there are certain rare cases in which the new growth infiltrates the whole liver, which is then enlarged and hard, but no nodules can be felt. We should never omit to feel the umbilicus, for the growth may spread along the round ligament to it, and, of course, we ought always to examine for enlarged glands over the left clavicle. When we bear in mind that malignant disease of the liver is nearly always secondary to malignant disease elsewhere, it is not surprising to learn that in half the cases in which in the post-mortem room malignant disease of the liver is found, it was unsuspected during life, for the primary malignant disease often kills before the secondary deposits in the liver have become of any great size.

Perhaps this is a suitable opportunity to refer to some difficulties of diagnosis with which I have been struck. We are often presented with this problem: Here is a patient with a large hard liver, and he is jaundiced. Has he malignant disease of it?—for in many cases the nodules of growth cannot be made out by palpation. About half the patients in whom during life malignant disease of the liver is suspected have jaundice and it is of great importance to bear in mind that the most frequent cause of long-standing jaundice is malignant disease. Jaundice in this condition may vary in depth a little from day to day in its earlier stage, but when once it has appeared it will continue, for it is nearly always due to the pressure on the bile duct of a gland in the transverse fissure, which has become enlarged from the deposition in it of malignant growth. The skin, slowly and deeply stained by bile, gradually becomes more and more green, and ultimately assumes a peculiar earthy, dark green tint, which, especially if the patient be aged and wasted, is almost diagnostic of cancer of the liver. There are few things more characteristic in medicine than to see an aged, grey-haired patient, extremely wasted, with dry, dark green skin hanging in loose folds, lying perfectly still, so drowsy that he is more dead than alive. If we turn down the bed-clothes, the liver may be seen deforming the shape of the abdomen, and it will be noticed that the sheets are stained yellow either from urine or sweat. It is excessively rare to get this green jaundice in any other condition than malignant disease.

Mistakes have occurred from not remembering that the evening temperature is often raised to some point between 99° and 101°, or even more; this may continue regularly for weeks, and there may be a leucocytosis up to 15,000. Only this summer I saw a patient in whom the characteristic feel of the liver made most of those who saw him pretty confident he had malignant disease of it. But some, arguing from the wide daily fluctuations of temperature, and the fact that there was a leucocytosis up to 15,000, thought there must be an abscess. The liver was explored, and was found to be affected with growth. In such a case of difficulty, the absence of rigors would be a point against pus, and the leucocytosis in abscess of the liver is usually considerable.

It may be hard to tell between a cirrhotic liver and one affected with malignant disease if nodules of growth cannot be felt but the liver appears uniformly enlarged. If the tangible lumps are large, there is no difficulty, for, as Sir William Jenner used to teach, if any of them are bigger than a cherry, the case cannot be one of cirrhosis, and the increase in the size of the liver is never so rapid as it may be in growth. It is only in the case of cirrhosis in which the liver is enlarged that difficulty is likely to arise, and in those cases the jaundice is rarely deep, and, I think, never green. Ascites is in favour of cirrhosis.

Impaction of a stone in the common duct may give rise to difficulty, but when there is a doubt the case nearly always turns out to be one of growth, for it is much the commoner, and it is rare for the impaction of a stone to last long enough for the jaundice to become very chronic. Usually the stone lying in the part of the duct which lies in the duodenum ulcerates its way into the duodenum, and the jaundice passes away.

Formerly primary malignant disease of the liver was thought to be much commoner than it really is. Frerichs gave the proportion of primary to secondary growths as 1 to 5. Now I think it is thought to be rarer than it really is. At Guy's Hospital the proportion of undoubted primary to secondary hepatic carcinoma is about 1 to 25, and other hospitals show the same. The reason for this discrepancy is that the older writers regarded cases of primary malignant disease of the gall bladder as examples of primary malignant disease of the liver. There are some interesting facts about primary malignant disease of the liver: it is commoner in men than women, although the secondary form is commoner in women than men. Probably it will be found that the temperature is more often raised in the primary than the secondary form, and jaundice is, if present, usually slight, and comes on late, and rarely, if ever, becomes dark green. The reason for these differences is almost certainly that the primary disease is, as a rule, more rapidly fatal than the secondary—indeed, it is extremely rare for the primary disease to last more than four months after the symptoms have first declared themselves. Mention of primary disease of the gall-bladder leads me to suggest that it is much more frequent than is usually supposed. Dr. N. F. Ticehurst found that among 11,031 post-mortem examinations at Guy's Hospital, there were 45 examples of primary carcinoma of the gall-bladder, and in 43 of these, or 95 per cent., gall-stones were present; in the same 11,031 post-mortem examinations there were 15 cases of primary carcinoma of the bile ducts, and in 75 per cent. of these gall-stones were present. These figures strongly suggest that gall-stones are the cause of the cancer, a view which is supported by the fact that the incidence of age and sex in the cases of gall-stones and carcinoma of the biliary passages is the same in both. Sometimes a definite history of gall-stone colic precedes the symptoms of carcinoma of the biliary passages, and sometimes an examination of the specimen strongly suggests that the gall-stones preceded the cancer. I need not trouble you here with the figures, but an analysis of our cases at Guy's makes me strongly suspect that in 20 per cent. of patients who have gall-stones, carcinoma of the biliary passages will follow, and this suggests that gall-stones should be much more often removed by the surgeon than is commonly done. Inasmuch as patients who are jaundiced bear operation badly, it would appear that the right thing to do is to remove them at a time when they are not causing biliary obstruction.

Sarcoma of the liver as a primary growth is excessively rare, and secondary sarcoma cannot be diagnosed from cancer unless we know that the primary seat of the disease is sarcomatous.

Syphilis is a very interesting cause of an enlarged liver. Taking first acquired syphilis, it is only in the tertiary stage that the organ is enlarged; it may be lardaceous, but that produces a uniform increase, and we are only here discussing irregular enlargements. These occur because syphilis produces a great increase of fibrous tissue and gummata. In 20 years at Guy's Hospital I find these effects of syphilis on the liver in the post-mortem room occurred 95 times, and in 23 out of the 95 cases gummata were present, and in the remaining 72 there was only scarring of the liver by fibrous tissue. Sometimes scarring and gummata were present in the same liver. During these 20 years about 9,500 post-mortem examinations were made, which shows that 1 per cent. of those who die in a general hospital have syphilitic fibrous or gummatous changes in their liver. As the fibrous tissue is so striking, the phrase, syphilitic cirrhosis, is often used, but this is a pity, because a syphilitic liver never resembles one affected with ordinary cirrhosis, for the new fibrous tissue forms great bands, several of which usually start from a common point and cut the liver up into large areas, which consist of perfectly healthy liver. In alcoholic cirrhosis the areas are never bigger than a hobnail, and the hepatic cells in the hobnail are fatty. These great fibrous bands, by their contraction, form scar-like depressions on the surface, and these may be so numerous and deep as to cut the liver up into a number of irregular masses, leading to great deformity of it. Gummata of the liver are just like gummata elsewhere. They often grow to the size of a tangerine orange, and then they shrink, so that they add greatly to the deformity of the liver. A single gumma is rare; usually two or three are present in the same liver. But it is clear from this description that, although the liver in syphilis may be lumpy and irregular, it is never very greatly enlarged, so considerable enlargement is a sign of malignant disease. The swellings in the liver in malignant disease may alter in size very rapidly; in syphilis the alteration is slow, although it may be quickened by treatment. There is no pain in syphilis unless there is some local perihepatitis over the gumma, and usually there is not. Pain, on the other hand, is common in malignant disease. Although jaundice and ascites have been recorded in syphilitic disease of the liver, and have been associated with either an enlarged gummatous gland or cicatrisation of fibrous tissue in the portal fissure, yet such events are excessively unusual. I can remember no case in point, so the presence of either jaundice or ascites is excessively strong evidence of growth as against syphilis. Then in growth we sometimes get the umbilicus and the gland over the left clavicle enlarged. To complete the picture of syphilitic disease of the liver, it should be added that it is much more often found in the dead-house than it is diagnosed during life, and that the association of lardaceous disease with the scarred and gummatous condition is very uncommon, but when it exists it may cause a very large liver. Unless it is remembered that congenital syphilis may produce exactly the same state of liver as that induced by the acquired disease, mistakes may occur. When this effect of congenital disease is first seen, the patient is nearly always between the ages of 10 and 20 years.

The pericellular cirrhosis of congenital syphilis, which is the cause of a uniform enlargement of the liver in infants, and which occurs in almost 50 per cent. of all the children with congential syphilis, is of much more histological than clinical interest, for it indicates that the congenital syphilis is severe, and many of the infants afflicted die early in life. It is usually not suspected unless the child has some of the ordinary signs of congenital syphilis, and if then the liver is enlarged considering the age, the enlargement is almost certainly due to syphilitic pericellular cirrhosis; but once I have known it to be caused by lardaceous disease

There is not much that calls for special mention about the enlargements due to hydatid or abscess. It is, of course, essential to remember that both lead to a local enlargement of the liver. Growth and syphilis are rarely confined to one part. However, this last summer, a boy, aged about 8, has been under my care for hydatid of the liver, and the organ contained at least three hydatid cysts; but, fortunately for diagnosis, one in the right lobe was so much larger than the rest that the enlargement of the liver was at first local—so much, indeed, that many distinguished members of the profession considered that the child had an enlarged kidney, for the hydatid was in the lower right hand part of the right lobe, and therefore this case illustrated what I pointed out a few minutes ago —namely, the difficulty of telling between an enlarged kidney and the right lobe of the liver. An examination of the blood is of great help in the diagnosis of hydatid, for considerable eosinophilia is present. Ten per cent. of the leucocytes may be eosinophiles; when the hydatid is opened the number of eosinophiles falls quickly. Fluid removed from an exploratory puncture of the right chest should always be boiled to see if any albumen is present. I have known forgetfulness of this lead to a serious result. Some fluid was aspirated from the right chest; it was assumed to be pleuritic. The patient was sent into the country for some weeks. When she came back I put a needle in again, drew off fluid, and found it contained no albumen, and so I concluded it was from a hydatid. Operation disclosed a huge hydatid growing up into the chest from the upper surface of the liver. She succumbed to the operation, but it is quite likely that if she had been operated on earlier she would not have done so. When hydatids or abscesses are small and in the upper surface of the liver, they may be detected if the upper margin of hepatic dulness is very carefully marked out, and a rounded eminence of dulness occurs on the top of the normal line of dulness. I have known this to be no bigger than half a crown, and yet an exploring needle withdrew pus.

As far as my experience goes, the leucocytosis is always considerable in hepatic suppuration, rigors are very common, and both they and the rises of temperature may occur at such regular intervals as to strongly suggest ague. It often requires a very careful physical examination, combined with an examination of the blood, to detect them. I remember a man who used from time to time to get an attack of shivering and rise of temperature. Many doctors saw him; most thought he had influenza; but careful percussion detected the abscess, which was successfully opened.

The next enlargement of the liver we have to consider is that due to cirrhosis. It is usual to describe two varieties—namely, that in which the liver is large —the so-called hypertrophic cirrhosis—and that in which the liver is small—the atrophic; but this is confusing, for there is an extremely rare condition known as hypertrophic biliary cirrhosis, which has nothing to do with ordinary cirrhosis. There is considerable evidence that first the liver in ordinary cirrhosis enlarges, and then becomes smaller. This is what we should expect, for all forms of fibrous tissue tend to contract as time goes on; indeed, cases have been recorded in which cirrhotic livers have become smaller under observation, and Dr. J. A. P. Price, analysing 142 cases of fatal cirrhosis at Guy's Hospital, found that in 80 the weight was over 60 ozs., in 33 the organ weighed between 50 and 60 ozs., and in 29 it was under 50 ozs. These figures show the futility of trying to draw a sharp distinction between hypertrophic and atrophic cirrhosis, for it would be difficult to know where to place the livers between 50 and 60 ozs. in weight, and these figures strongly suggest that the liver is at first larger than normal, for the number of those with a large liver is greater than those with a small, and naturally we should expect the number of patients to lessen as the disease went on, for some would die in the course of it; and that the atrophic livers are only a later stage of the hypertrophic is further borne out by the fact that those with large livers are on the average younger than those with small, and all supposed differences in the symptoms are really due to the fact that certain symptoms are more likely to appear late than early.

Although it is a little outside the title of this paper to do so, I should like to point out that alcoholic cirrhosis is an incorrect name for this disease of the liver, for although the taking of beverages containing alcohol undoubtedly plays an important part in causing the disease in many patients, alcohol cannot be the sole cause, for some patients, notably some children, who suffer from the disease have not taken any alcohol.

It cannot be produced by the administration of alcohol to animals, and in many parts of the world—*e.g.*, Scotland—much alcohol is consumed, but cirrhosis of the liver is rare. It is, I think, undoubtedly commoner among the lower than among the middle and upper classes, and this was the opinion of Sir William Gull and Sir George Burrows. It certainly may exist without any symptoms being present during life. Thus a large cirrhotic liver may be detected in the routine examination for a life insurance, and it is frequently found in the post-mortem room when it has not been suspected during life. The symptoms are well known. Perhaps that least appreciated is the slight pyrexia that may be present; but, speaking generally, this is not so high as it may be in malignant disease of the liver. It may be very difficult during life, and even after death, to tell a cirrhotic from a malignant liver, but facts that will guide us in a local examination are that hobnails are never umbilicated, are never larger than a small cherry, and never become suddenly larger. The irregularity of a liver affected with malignant disease is usually much greater than one which is cirrhosed. Cirrhosis of the liver is often regarded as a local disease of the liver, and it is thought that the pressure of the contracting fibrous tissue on the portal vein leads to the ascites; but this cannot be so, for the fluid in the abdomen usually collects rapidly, sometimes at the rate of a pint a day, which would be very difficult to understand if we believed that the slowly forming fibrous tissue, by its compression of the portal vein, was the sole cause of the ascites. Again, a high degree of cirrhosis may be found in the post-mortem room in cases in which the disease was unsuspected during life, and in which no ascitic fluid existed in the abdomen. Then, again, the amount of ascitic fluid bears no relation to the degree of cirrhosis. It is not most evident when the hæmatemesis suggests that the portal pressure has been high, and it certainly is not due to portal thrombosis, for that is very rare. No obstruction to the portal vein can be demonstrated after death in cases of cirrhosis. It seems to me that the correct view to take is a much wider one, and I believe that, possibly as a result of the damage to the liver, or possibly from some other unknown cause, certain poisons circulate in the blood of a patient with cirrhosis. Possibly they are poisons from the alimentary canal which the cirrhotic liver cannot destroy. If such a poison is a lymphagogue, we have the explanation of the ascites, and also of the œdema of the feet, which is so often seen in cirrhosis. Probably other symptoms are due to the poison, such as the coma and delirium which are seen quite apart from jaundice. The slight pyrexia, wasting and anæmia may in part be due to the same poison. Indeed, unless we believe that such a poison exists, it is difficult to say why cirrhosis should be fatal. The mere cirrhosis of the liver, I would suggest, does not matter much so long as the poison does not get into the circulation, but a person with a cirrhotic liver is at any moment liable to this; then he quickly becomes dangerously ill This view is supported by the fact that when ascites, or coma, or convulsions appear, the patient is, as a rule, within a few weeks of his death, although previously it may not have been known that he is ill. On this view cirrhosis of the liver is like a granular kidney, for a patient may have this for years without knowing it, and then suddenly he becomes uræmic, and is often dead in a few days.

Austin Flint, Watson, Niemeyer, Murchison, Fagge, and many of the older authors taught that the onset of ascites was of very serious moment, for they said if it was much the patient died within a few weeks of its onset. This opinion has been much doubted; so, to investigate the point, I took a number of fatal cases from the records of Guy's Hospital. In ten ascites was present, but the patient was not tapped, but, as far as could be ascertained from the history, the time from first noticing that the abdomen began to enlarge till death was on the average only two months, and the same was true of twelve that were tapped. Dr. Campbell Thomson and others have collected cases from other hospitals which quite support this contention. The onset of swelling of the feet, and the development of nervous symptoms, both also indicate that the end is not very far off.

It is quite impossible, in this brief article, to give a detailed account of that very rare disease, "Hanot's cirrhosis," which has nothing to do with alcohol, occurs chiefly in children, is very slow, and is characterised by the fact that the liver and spleen both become very large. The patient is often stunted in growth, and the fingers may be clubbed Nor can we say much about the form of cirrhosis with a large liver that follows enlargement of the spleen in splenic anæmia, and constitutes Banti's disease. Both this and "Hanot's cirrhosis" are so very rare that they seldom come before any of us. Some observers claim to have produced cirrhosis of the liver by ligature of the bile ducts; but it is doubtful whether this follows if the ligature of the ducts is performed aseptically, and certainly if such a cirrhosis exists in man, it must be quite exceptional, for growths and gall-stones frequently obstruct the duct, and yet no cirrhosis follows. Indeed, most physicians doubt whether there is in medicine such a thing as "obstructive biliary cirrhosis." Malarial cirrhosis has been described, but it does not exist. The mistake of ascribing cirrhosis to malaria has arisen from the fact that many people with malaria have taken more alcohol than they should, and the doctor has kindly wanted to whitewash them, and so has attributed to them malaria cirrhosis which should have been laid to the door of alcohol. It has been said that rickets, diabetes, gout, cancer, tubercle, passive congestion, lead, dyspepsia, and scarlet fever will all give rise to cirrhosis of the liver, but this is a misuse of histological knowledge as applied to clinical medicine. Occasionally, perhaps, a slight increase of fibrous tissue may be detected by the microscope in patients dead of these diseases, but this is never enough to cause the liver to look or feel like a cirrhotic liver; or are the symptoms of cirrhosis ever present. The writings on the subject of cirrhosis are most confusing, but I would suggest that the truth is as follows: There is a common disease—cirrhosis of the liver. No distinction should be drawn between hypertrophic cirrhosis and atrophic cirrhosis, except to express different stages of the same disease. Rare forms of cirrhosis are "Hanot's cirrhosis" and that of Banti's disease. There is a pericellular cirrhosis which often accompanies congenital syphilis. Beyond these conditions there is nothing to which the term cirrhosis of the liver should be applied. Acquired syphilis produces quite a different appearance of hard bands of fibrous tissue with large areas of healthy liver in between.

Simple cysts of the liver, innocent tumours and actinomycosis of it are so rare that we now have only left uniform hepatic enlargements, and, of these, that due to backward venous pressure is the commonest, and is nearly always associated with mitral disease. This nutmeg liver is often larger during life than it appears when cut out of the body, for then much blood has drained out of it. When it is large, the lower edge may reach to the umbilicus, the hepatic enlargement often causes much distress from the feeling of tightness and discomfort of which the patient complains, and it may be that the difficulty of lying down which is so common in heart disease is sometimes due to the direct pressure of the large heavy liver on the heart. If the heart has failed rapidly, the liver is often very painful and tender, and then much benefit follows the application of leeches. In a few cases an expansile distension can be felt synchronous with each beat of the heart, if one hand is placed on the front of the liver and the other behind it. Care must be taken to satisfy oneself that the pulsation is expansile, for the dilated and hypertrophied heart may transmit a jog to the liver at each beat, and sometimes the abdominal aorta will do the same.

The liver is frequently found in the post-mortem room to be fatty, but often this change is associated with cirrhosis, or it does not lead to any enlargement of the organ, and even when it does the patients may be so obese that no enlargement of the liver can be detected during life. Hence fatty liver is not of the clinical importance that might be thought. Nevertheless, the soft enlarged fatty liver may often be detected during life, and successfully diagnosed if any of the many causes that lead to a fatty liver are present. It is of considerable importance to detect it, if possible, for those in whom it can be detected are always in a precarious state of health, and bear operations and serious illness very badly.

The liver is affected in half the cases of lardaceous disease. It may be enormously enlarged, and is smooth and hard. Lardaceous disease often used to follow upon prolonged suppuration, but as surgery does not often allow this nowadays, lardaceous disease is becoming rare. I have seen the lardaceous liver become much smaller after the surgeon drained a chronic abscess connected with the hip. Phthisis and syphilis are much better treated than they were, and therefore, for both medical and surgical reasons, we do not nearly so often see a lardaceous liver as formerly.

The uniform enlargement that follows blocking of the bile duct is only of clinical interest in the few cases in which the presence of jaundice and an enlarged liver leads to a difficulty of diagnosis between malignant disease of the liver and an impacted gall-stone.

I am afraid I have wearied you, and told you nothing which is not common knowledge; but as I said at the beginning, as this is essentially a clinical meeting, my object has been to quickly pass in review such features of enlargement of the liver as are of clinical interest.

Note.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor R. Lepine, M.D., of the Lyons Faculty of Medicine. Subject: "Uræmic Meningitis."***

ORIGINAL PAPERS.

SUDO-KERATOSIS.

By R. W. BRIMACOMBE, M.D.

Assistant Physician to the Skin Department, Kensington General Hospital, and late Pathologist to St. John's Hospital for Diseases of the Skin.

Sudo-Keratosis (Sweat Keratosis) is the name I have given to a disease of the skin, involving the sudoriferous apparatus, and its principal feature is a keratosis of the sweat duct, mainly at its outlet. I have considered it of some importance, because I have not been able to find it in the nomenclature of skin diseases. The accompanying clinical and microscopical diagrams, which I exhibited at a recent meeting of the British Medical Association, clearly indicate:

(*a*) the distribution clinically;

(*b*) microscopically, that the disease is confined almost entirely to the sweat ducts.

The case which came under my notice was that of a boy, æt. 12, belonging to the very poor class. He presented a dirty, ragged appearance, and I have no doubt "dirt" was the principal factor in the origin of this disease.

Clinical.—The dorsal aspect of the hands only were affected, the disease limiting itself to the metacarpal joints (Fig. I.), where no hairs are present. The papules are mostly discrete, slightly raised, with a flattened surface and of a semi-transparent, somewhat hyaline character. The centre of the papule was occupied by a black speck, which gave it a comedo-like appearance.

Microscopical (Fig. II.).—A section of skin (papule) hardened in alcohol, and stained with hæmatoxylin and eosin, shows the lumen of the duct filled up with a plug of nucleated horny cells, hypertrophied and cornified. The lumen is widely dilated, and on each side of it and surrounding it is a layer of hyaline structure without cells. The hyaline structure also pervades the horny cellular mass, and binds the horny cells together. The strata corneum and lucidum are obliterated by the hyaline layer.

At the top of the plug is débris, seen by the naked eye as a black speck, and the plug itself contains masses of deeply-stained wandering cells (polynucleated leucocytes). These cells are minus their nuclei; they have undergone degeneration, become dried up and calcified, and show a diffuse blue staining. Where these cell masses are located, the channel passing through the nucleated horny mass is pressed upon, and consequently becomes blocked up, whilst in the intervening spaces the channel still remains patent.

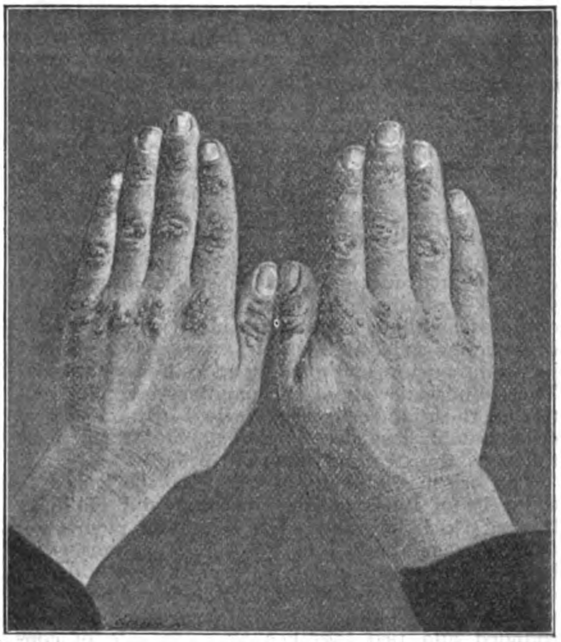

Fig. I.

With Zeiss A Ocular II., the plug appeared to be studded with irregularly-distributed dark pigment granules, and under the oil immersion lens the granules at first led one to think a small micrococcus was present in chains and groups. Further observation, however, showed that they were not pigment granules or micrococci, but free granules without any stain. The sides of the funnel have become partially denuded of their stratum granulosum cells, and the granulated kerato-hyaline cell showed that the supposed pigment granules and micrococci were really the granules remaining from the kerato-hyaline cell, which cells have become dried off, leaving the granules free.

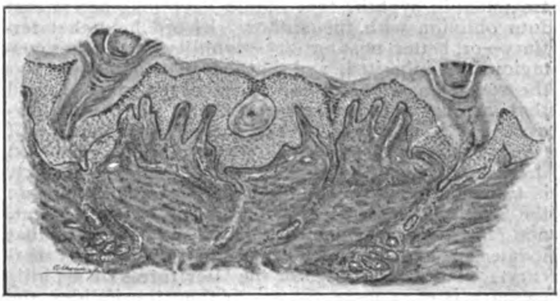

Fig. II.

The stratum granulosum cells on either side of the plug are hypertrophied, except at the lower portion of the plug, where the cells have disappeared and become converted into horny cells, so that the plug comes into actual contact with the stratum mucosum layer. The cells of the latter layer are swollen hyaline, and the nuclei enlarged, with a marked increase in depth of layer, especially around the dilated duct.

The cells of the papillary layer are also enlarged and the papillæ widened, the capillaries surrounding the duct only are dilated with small celled infiltration around.

There is a slight increase of spindle-shaped connective tissue cells in the cutis. Cornification stops in the epidermis, the epithelium of the sweat duct in the cutis is merely swollen, the lumen of the duct moderately dilated and free. There is some slight swelling of the epithelium of the sweat glands, together with dilatation of the lumen.

Owing to the hyaline condition of the epidermis surrounding the duct, although the papillæ are widened, the capillaries dilated, and an inflammatory infiltration is present in the cutis, clinically, these signs are not present, the papules having a pale semi-transparent appearance. An interesting feature in a microscopical specimen is the presence of epithelial giant cells situated on the right side of the dilated duct only, and in a large number of sections examined the left side of the duct was occupied by dilated capillaries and lympathics with small round-celled infiltration, a few sections showing commencing epithelial giant cell degeneration. The cylindrical cells of the papillary layer in relation to the giant cells are lessened in number and development, less deeply stained, and their place taken by the stratum mucosum cells.

The origin of the giant cells may be traced to the cells of the stratum mucosum and papillary layers, which have been left behind or pushed off from the epidermis into the cutis, or, more probably, their development is from the endothelium of the lympathics and capillaries, on whose site they occur. The giant cells are grouped, surrounded and tied together by a capsule of connective tissue cells, and under the low power are seen as a definite hyaline patch.

TREATMENT OF TERTIARY SYPHILIS.

By DR. M. VON ZEISSL,

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TRADITION prevails in disease as much as it does in Art. In the therapy of syphilis old-established notions have led practitioners to maintain a rigid course of treatment in syphilis that should have long ago passed into oblivion with the author. Ricord held that tertiary—or, better, post-tertiary—syphilis was neither contagious nor inherited, and that iodide of potassium was the sovereign drug for this form of the disease, and that mercury was injurious, and had no effect whatever. It is now some years since I satisfied myself (1887, I think), by experiments and clinical testimony, that post-syphilis, as well as primary and secondary, is transmissible, and that mercury is as efficacious in the one as the other. Like the trail of the serpent, one class-book after another hands it down to us that iodates act more potently in tertiary syphilis than mercury. This is an error. In the later forms of syphilis mercury is even more efficacious than the iodides, the latter being always more protracted than the former. The mercurial preparations are always more energetic in all forms of syphilis. Like the application of mercury, the diagnosis is often misleading by its peculiar nomenclature. The papules on the iris by many are called gummata, while this is nothing more than a papular syphilide corresponding with those on the body.

This gummatose phenomenon is one of those changes that seems to exhaust itself or become modified by treatment, as it is now seldom met with in Austria and other countries where early treatment prevails. The treatment is usually applied early, and continued energetically for some time after all symptoms of the disease have disappeared, and renewed at a later period if any other symptoms should present themselves.

In Dalmatia, Bosnia, and Russia, at the present day, gummata are common, and are received at hospital every day, while in Vienna you will rarely meet with one. This was not always the case with us, as many of the older physicians know, but it is encouraging to reflect that the hideous morbid changes that used to deface our wards have quite disappeared from our midst.

There is still amongst us a serious result of syphilis that does not exist in Constantinople, where gummata are plentiful. With us disease of the central system is unhappily too frequently the result of the syphilic poison, which is not found in the Orient, no matter how badly neglected the treatment may have been. This is the experience of Glück and Dühring, of Sarajewo and Constantinople. The lecturer saw, while he was in Herzegovina, Bosnia, and Dalmatia, 370 cases of syphilis which he had to treat, and only four out of this great number, which were old cases, had any symptom of either central nerve symptoms or peripheral phenomena. It would seem from these results that worry and abuse of alcohol are necessary for the production of any nerve disturbance in the brain or spinal cord, which may explain the large number of resulting nervous diseases met with in France and other countries, where alcohol is used. Many of these cases are neurasthenic, and doubtless suffered in the past from the forced anti-syphilitic treatment usually practised, where treatment is readily obtained. It is quite possible that this over-treating may do a great deal of harm and no good to the disease, but under the false name of "preventative" it is foolishly resorted to. No such treatment will prevent recurrence, and no treatment should be commenced until undeniable syphilitic phenomena appear. Any other proceeding is injurious. The following may be cited as good examples of the futility of such heroic treatment as preventative:—

G. H. was infected, when 24 years old, in March, 1902. On the first appearance of any syphilitic phenomena, he presented himself at the "Garnison Spital," and there underwent energetic treatment. He received 40 inunctions, 10 rubbings, 3 grammes, ten 4 grammes, and twenty 5 grammes, making a total of 75 grammes of mercurial ointment. During the same period, which extended over two months, he took internally 2 grammes of iodide of sodium. During 1902, 1903, 1904, and 1905 he underwent 30 days' inunction, with a bathing or drinking cure at the Darkau Hydropathic. During this interval of preventative treatment none of the syphilitic phenomena presented themselves, which I can vouch for, having him under my constant observation at the Garnison District, where I was located. The last inunction was given on May 29th, 1905. On June 31st he came to the baths for his annual cure, and told me that he purposed marrying in February, 1906, which I thought a wise proceeding, as the primary examthemata had appeared in 1902, and during the long interval no symptom of syphilis had reappeared. Notwithstanding this satisfaction in my own mind, I asked him to undergo a short mercurial treatment before marriage as a precaution against any recurrence, and on this occasion 30 intra-muscular injections of succinamid of mercury, with internal doses of .05 to 5.00 grammes of the proto-iodide of soda and mercury in pill form. On February 16th, 1906, no sign of lues was to be observed. He returned from his honeymoon on March 21st, and consulted me for an abrasion on the scrotum which had inflamed the cutaneous surface of the penis, where a few weeping papules were observed. The wife had not menstruated since marriage, and complained about March 8th of pain during coitus. On examination, I found in the posterior commisure on the left vaginal wall near the insertion of the labia minora a small infiltration about the size of a hazel nut, which I removed with a knife. The inguinal glands were numerous and swollen, and no doubt remained in my own mind that she had been infected with the syphilitic virus. On April 19th the syphilitic roseola appeared, and I at once prescribed proto-iodide of mercury, 1 gramme, in 50 pills, one to be taken four times a day. At the same time a vaginal douche in the evening, followed by the insertion of a suppository containing 1 gramme of mercurial ointment. The roseola soon disappeared, followed in June by papules on the mucous membrane of the mouth, tongue, etc., upon which I changed the treatment to mercurial vasogen inunction. During the whole of this time she took per-os 1½ grammes of the iodate of soda in pill form, and from the beginning of the pregnancy to the end she took 5 grammes of the proto-iodide internally, 100 suppositories of 1 gramme each, and 80 inunctions of 3 grammes each of mercurial ointment. On November 28th a child was born weighing 3,150 grammes, healthy and strong, and free from every appearance of syphilis. This year, on April 21st, the child weighed 7,000 grammes, and no symptom of syphilis had appeared. The child had been fed on sterilised milk, as it was unwise of the mother to feed it, and equally so for the child to be put to the breast of a healthy nurse. A peculiar symptom should be noted; on the second day after the confinement papules appeared on the tongue of the mother, which again disappeared after a few inunctions while confined to bed.

Here we have a man who has taken every precaution that the science of medicine can suggest to eliminate by mercurial purgation every trace of that syphilitic fiend, even up to the very eve of his marriage, and yet he is able to infect his wife two years after every symptom had disappeared, and, notwithstanding this infection, with energetic mercurial treatment a healthy child is born into the world.

A similar result was obtained in 1905 in the case of a painter whose wife was infected, became pregnant, and was diligently treated with succinamid injection and given iodide, and a healthy child born. The child appeared strong and robust, but in the fourteenth month whooping-cough developed, followed by inflammation of the lung, and it died within 15 days. There is another case demonstrating the fact that we can treat syphilis quite successfully in keeping it suppressed, but we are unable to prevent its occurrence by any protective means we have at our command; but the strange anomaly still exists that if pregnancy intervene a healthy offspring is the result. With these facts before us, it is useless to attempt the impossible in irradicating a poison that will occur in spite of the most persistent treatment. It is therefore better to guide the local symptoms by treating them as they arise with mercurial plasters and iodoform bandages when necessary. When these tertiary results appear on the forehead as periosteal gummata, with fluctuation, antiseptic punctures will often check the formation of abscesses, avoid deformity and a good deal of suffering. When necrosis does occur it is always better to have the loose sequestra extracted. If these be left until Nature throws them off, the health may suffer, and the patient become so much weakened that life may be endangered, but the early interference of the surgeon will avert this result and hasten recovery. In many of these cases free mercurial treatment may modify the gummatose phenomena, and happy results be obtained. In this class of cases the decoction Zittmanni, which is a combination of mercury and sarsaparilla, will be found efficacious. The addition of calomel or other forms of mercury are quite unnecessary if the Zittmanni decoction be made with fresh sarsaparilla, and not with a fluid extract or tincture that has been long prepared. A course of bathing is also a very favourable adjunct in the tertiary treatment where general disturbances of the nerve centres are troublesome. Recurrences in the mouth and throat are readily induced by the abuse of alcohol and tobacco, which should be forbidden in the tertiary form.

It is worthy of remark that orchitis syphilitica seldom passes on to suppuration of the scrotum. If a hydrocele should occur, it will probably spontaneously disappear owing to the disturbance in the vascular system; but when the distention becomes painful it is better to draw the fluid off. As a rule the swelling will recede if the part be enveloped in mercurial ointment in the form of plaster or otherwise. According to the testimony of Levin, bilateral orchitis will lead to oligo- or azoöspermia. In one case of my own, [illegible] destruction of the testis prompted me to [illegible] ni-castration, which the patient would not listen to. The consequence was that one half of the scrotum necrosed, and after four months' treatment cicatrised. A hint might be given to the younger practitioner that the application of mercurial ointment or plasters should be carefully done, as gingivitis or mercurial intoxication may also be induced by this innocent form, and do considerable damage.

Modern treatment has given rise to a number of new preparations, such as sajodin jodalbumose, with the object of making iodine borne easier by the stomach. These are absolutely tasteless, and have the advantage of producing no acne. Iodine catarrh is a troublesome accident producing neuralgia in the trigeminus, which is seldom met with in sajodin or jodalbumose. When the catarrh appears it is better to suppress the iodide in every form at once, and if the soda or potassium iodide have been used, it is better to vary it with the newer class of drugs. In very sensitive cases the pill form is the best, as potassium sodium or iodide, when given in solution, act directly on the mucous membrane, inducing the injury we wish to avoid. Pleurodinia of the left side, and œdema of the glottis and lungs, are also troublesome symptoms of the iodide poisoning, which may frequently be relieved by the addition of 0.03 gramme to 00.5 gramme of quinine to the mixture; this adds to the better digestion of the drug. It is always better to prescribe iodates after meals to relieve the irritation of the stomach, and jodalbumose has been prepared in tablet form, containing 22 per cent. of the drug, to meet this difficulty. This seems to act well, as no increase of the heart's action has been recorded after its use. Iodide acne is another troublesome symptom which readily yields to the combination of cerolin.

Another new drug, named mergal, a mercurial preparation, has recently been introduced in the form of capsules containing 0.05 gramme, and gives excellent results. My own experience is very favourably inclined towards this preparation since its introduction to the Austrian clinic.

PHYSICALLY DEFECTIVE CHILDREN FOR WHOM INSTRUCTION IN SPECIAL SCHOOLS IS NECESSARY. (a)

By REGINALD CHEYNE ELMSLIE, M.S., F.R.C.S.,

Local Assistant Medical Officer to the Education Committee of the London County Council; Assistant Surgeon to the Metropolitan Hospital, London.

It is now eight years since the School Board for London opened the first "Invalid Centre" for the instruction of children who, owing to chronic ill-health or to physical defect, were unfit to mix with their fellows in the larger schools. The number of centres has rapidly increased, until at the present time there are twenty-three open, with accommodation for 1,428 children, and with 1,802 children actually on the roll—a sufficient number to render a survey of these children from the medical standpoint both interesting and instructive.

The schools are dotted about all over London; each accommodates from forty to one hundred children, drawn from a district which may have a radius of one and a half or two miles, ambulances being used to collect the children in the morning and to take them home in the afternoon. A qualified nurse, a cook, and one or more helpers are in attendance at each school; in addition to their other duties they prepare a mid-day meal, for which the children pay. A voluntary association assists in this catering, and also provides food at a reduced rate or free in cases of want.

Children are passed into the school after examination by a medical officer, who also periodically sees all children in attendance. Notes of their histories and of any changes in their condition are kept in a case book. They are required to remain at school until the age of sixteen, unless they are passed to leave or to return to an elementary school at one of the medical officer's visits.

(a) Paper read before the Second International Congress on School Hygiene, London, 1907.

During the past year I have kept careful record of the condition of 1,050 children seen and examined by myself in these schools. As far as possible details as to the disease or deformity from which they suffered, the age at which it arose, the treatment which had been carried out, and the result as shown by the present condition of the child, were noted. With the co-operation of the teachers further notes as to the educational backwardness of the child, the amount of schooling lost through illness, and any notable deviations from the average in ability, were taken.

This number (1,050) represents only a small proportion of the physically defective children in London; but having been taken without selection, we may accept these children as a fair sample of the whole. From a consideration of them I propose to show—

1. What classes of children are at present being educated in the London schools for physically defective children;

2. What purpose is being served by educating these children, what results are being obtained, and generally whether the system is a desirable one.

The general classification of these children is set out in the table. The first point calling for attention is the group of seventy-two children who suffer from none of the conditions for which these schools are primarily intended. This group comprises a small number of semi-blind, semi-deaf children, too bad for education in an ordinary school, too good for a special centre for the blind or deaf, and a larger number of children suffering from no definite illness or defect whatever. The latter were found to be even more backward in their school work than were children suffering from such chronic ailments as tuberculous disease of the hip or spine. They are a group of delicate, nervous children, who have missed much schooling owing to illness; they are unfit to mix with healthy children in a large school, and until the London Education Authority sees its way to the provision of special accommodation for them a certain proportion of them must be found places in the schools for physically defectives.

Turning to the children for whom these schools are more specially intended, it will be seen that just about one half of these are suffering from tuberculous disease of the bones or joints, the hip or spine being the site of the disease in the majority of cases. Indeed, it is for the care and education of those children who suffer from the more severe forms of surgical tuberculosis that these schools may be said to be primarily intended. The age at which these diseases usually arise is of importance. From those cases in which the history had been recorded the following facts were made out:—

In tuberculous disease of the spine the disease arose between the ages of one and five in 72 per cent.

In tuberculous disease of the hip the disease arose between the ages of two and six in 64 per cent.

In tuberculous disease of the knee and of other joints the incidence was spread equally over the first nine years.

These facts agree with such statistics as have been published from the records of hospitals. They indicate one great difficulty which is bound to arise in dealing with these children in schools, viz., that the disease is already well established, and much deformity has often arisen, long before school age is reached. For example, of the children with disease of the spine who were examined, in only about 10—15 per cent. was the disease considered to be active, whilst 58 per cent. had very severe fixed deformity of the spine.

Many of the observations made upon these children are of purely surgical interest; some, however, also bear very directly on education. In the first place, the actual mortality from the disease is not high, but a considerable proportion die from intercurrent affections. We may take it, however, that the majority of the children will live to adult life, will then outgrow the actual disease, but be left with the deformity to which it has given rise. They will then have to take their place in the world, and to endeavour to earn their livings in competition with others who do not suffer under the disabilities of a fixed deformity, and of educational backwardness, the result of prolonged ill-health. Surely, then, our endeavour should be at one and the same time to prevent or alleviate deformity, and to carry on instruction during the periods of illness.

Now, in examining a series of cases of quiescent tuberculous disease two points stand out at once. The first is the frequency with which disease which was apparently cured reappears. A great physician has said of tubercle in the lungs that it is often arrested, very rarely cured. The same is true of tubercle in the bones and joints; over and over again a child with hip disease remains apparently cured for a year or two, then some slight accident, a little over-exertion, or some affection of the general health lights up the disease afresh, and treatment has to be carried out all over again. For this reason I am convinced that this class of children should be kept out of the large schools, no matter how well they appear to be. To allow them to mix commonly with their healthy fellows, to play rough games without supervision, frequently ends in disaster.

The second noticeable fact is the large proportion of these children who are left, when the disease is arrested or cured, with a severe deformity which seriously affects their prospects in after-life. Now this is not unavoidable; fully half the deformities following on tuberculous disease are due to three causes which may be overcome. The first is the commencement of treatment at too late a stage; this is remediable to a certain extent by increasing medical inspection, and by training those having charge of small children to consider any weakness of the spine or limbs as serious. The second is too short a period of rest in recumbency during the active stage of the disease; and the third, I regret to have to say it, is meddlesome operative surgery. These last two are not by any means altogether the fault of the surgeons. Owing to the absence of special accommodation for these children most of them have to be treated at the large general hospitals. Here there is a constant pressure upon the beds; there are always more patients waiting for admission than it is possible to find room for in a reasonable time. Moreover, some of the central hospital funds base their grants to hospitals upon the average length of stay of the patients; so that the latter have to be discharged at the earliest possible moment. This rule may be considered necessary to prevent abuse, but it certainly is not in the interests of the patients, and it is particularly bad in its effect on the treatment of children with tuberculous bone disease. They are taken in during some acute exacerbation of the disease, or for an operation, are discharged as soon as possible in a walking splint with crutches, and are then seen at intervals as out-patients. It would be almost impossible to conceive a more thoroughly bad method of treating them.

One result of this method is that children are constantly being taken to a fresh hospital, the parents are dissatisfied with the progress, or perhaps, having stayed away from the out-patient department too long, are afraid of receiving a scolding on returning. Meddlesome operation can be traced to the same causes. The operations to which I specially refer are excisions of the hip and knee joints; these have the advantage that they sometimes cure the actual disease right away by removing all the diseased structures. The surgeon, knowing this, and encouraged by the success of bold operating in other lines, seizes the opportunity of curing the patient after only a brief stay in hospital. The ultimate result several years after is seen probably at another hospital by another surgeon, who ascribes it to a bad operation, and never suspects that many of the excisions that he himself has done have turned out every bit as badly. Among the cases of old hip disease seen by me, twenty-five had been subjected to excision, and in every one of these a weak, flabby joint was left, the functional result being in every case bad. Similarly of thirty-four children on whom excision of the knee had been performed, twenty-nine were left with a severe deformity. I have no wish to condemn these operations entirely; in their proper place they both are of use, but if they are indiscriminately employed in an attempt to arrest the disease rapidly, not only are they often unsuccessful in this object, but also they often lead in the end to a crippled and useless limb.

The second group of cases includes children suffering from various congenital or acquired deformities, the latter chiefly the result of severe rickets, from infantile paralysis, and from spastic paralysis. These have the characteristic in common that the disability is of a fixed nature; it may in some cases be improved by surgical treatment, but it will not become worse as age advances. These conditions also are either present at birth, or arise in the first two or three years of life. Only the more severe cases of such deformities and paralyses require education in special schools; in the slighter cases the children are quite fit to mix with their healthy fellows. The requirements of this class of children are (1) constant medical supervision during the years of growth, to ensure that they are so treated as to leave them under the least possible disadvantage; (2) special education to fit them for the special work which their crippled condition will necessitate.

The third class includes children with heart disease, with progressive forms of paralysis, and with epilepsy, chorea and some other chronic illnesses. These are alike in that many of them will never reach adult life at all, whilst those who do will as a rule not be fit for any form of manual labour. Their requirements are similar to those of the last class.

Having shown what children are being educated in the London schools for physically defective children, let us consider what the present methods of work are accomplishing. These schools may aim at one or other of two objects:—

1. Simply to educate the children as far as possible, then to turn them out into the world ignoring their physical defect.

2. To do the utmost to arrest, alleviate or improve the physical defect, and by improving the child both educationally and physically to place him in such a position that he is able to support himself.

In London at present it is the first of these policies that is adopted, certain additions to it, however, being made. The additions are:—

1. Supervision in school by a nurse and a doctor, and occasional recommendation of treatment.

2. The provision of good food.

3. Voluntary aid by the local charitable societies, which as a rule keep in touch with the children in school through the managers.

4. Assistance in finding suitable work after leaving schools through the after-care committees.

These are all very good so far as they go, but those who assist in carrying them out would, I am sure, be the first to admit that the results are most unsatisfactory. In the first place, the work is voluntary, is not always systematic, and is carried out by energetic people, who mean well and work hard, but too often have an insufficient technical knowledge, and have no one upon whom they can fall back for advice and assistance. In the second place, we have no power over the careless, improvident parents, who are too lazy or too neglectful to make an effort on behalf of their own children, and who, perhaps, object to the offer of the after-care committee to get their boy apprenticed, because it means that they will lose the immediate return they might get from his wages as an errand boy, or in some similar occupation.

The problem of finding suitable work is rendered more difficult by the backwardness of the children, nearly all of whom are two standards behind their proper position, and many a great deal more than this. Moreover, the special nature of the work required is a further difficulty; the estimate arrived at upon this point was that only 20 per cent. of these children will be able to earn their living at any ordinary form of occupation, 50 per cent. will be able to work if special skilled work is found for them, the other 30 per cent. will either not live, or will be totally unfit to support themselves in any way whatever.

Practically, then, although much good is done in individual cases, in London at present a large number of these children are turned out into the world at fifteen or sixteen to make their way as best they can, their physical defect being ignored. And although it may be said that the education authority has done its duty in educating them, the community at large must be the poorer by having a number of physically unfit individuals left upon its hands. Without entering into particulars of alternative schemes for dealing with the problem, certain essential points which should be provided for in such schemes may be named.

1. Three classes of children must be provided for:—

(*a*) Children with tuberculous disease of the bones and joints.

(*b*) Children with fixed deformities and paralyses.

(*c*) Children with diseases of the heart, lungs, etc., of a chronic nature.

2. For children of the first class treatment at the earliest possible time after the disease shows itself is essential, and as these conditions arise early in life, provision must be made for quite young children.

3. Whether the institutions provided are called hospitals or schools is immaterial; they must serve both purposes.

4. Technical instruction is essential for the older children.

5. For certain cases the provision of a permanent home is desirable.

EXAMINATION OF 1,050 CHILDREN IN LONDON SCHOOLS FOR PHYSICALLY DEFECTIVES.

I.—Children for whom Instruction in Special Schools is necessary on Account of the Physical Defect.

	Boys.	Girls.	Total.		
A.—Tuberculous Disease of					978
1. Spine	106	80	186	480 (about 50 %)	
2. Hip	100	95	195		
3. Knee	46	34	80		
4. Other Bones or Joints	8	11	19		
B.—Fixed Deformities or Paralyses.					
5. Various Deformities	66	71	137	315 (about 30%)	
6. Infantile Paralysis ...	57	57	114		
7. Spastic Paralyses ...	27	37	64		
C.—Various Diseases.					
8. Heart Disease ...	61	59	120	183 (about 20%)	
9. Progressive Paralyses	8	1	9		
10. Various	22	32	54		

II.—Children for whom Instruction in Special Schools is not necessary on Account of the Physical Defect.

	Boys.	Girls.	Total.	
D.—Defects of Eye or Ear only	9	8	17	72
E.—Without Special Defect...	26	29	55	
Totals	536	514	1,050	

Children with more than one physical defect were included under that defect which was considered to be the most serious.

THE OUT-PATIENTS' ROOM.

THROAT HOSPITAL, GOLDEN SQUARE.

Foreign Body in the Nose.

By **Frank Rose**, M.B., F.R.C.S.

Among the out-patients was a little girl, æt. about 5, who had been brought by her mother on account of a discharge from the right side of the nose which had been noticed for about a fortnight; there had occasionally been a little blood with it. The mother did not know the cause, but seemed inclined to attribute the trouble to a blow which she vaguely intimated the child had had in the playground. On examination, a thin and purulent discharge was seen issuing from the right nostril; the upper lip on the same side was red and excoriated. Mr. Rose pointed out that the case was certainly either one of membranous rhinitis or foreign body in the nose; sinus suppuration was excluded by the child's age. Membranous rhinitis, though possible, was unlikely, he said, because it nearly always attacked both sides of the nose, though occasionally it was unilateral. Therefore, the only probable diagnosis was that of a foreign body. On suggesting to the mother that some foreign body had been introduced into the nose, she denied the possibility. After wiping away the discharge from the anterior part of the nose, a dark green body became visible. A blunt hook was then passed in behind this body, and a boot button was brought out, much to the astonishment of the patient's mother. Mr. Rose laid stress on two points. (1) That a purulent unilateral discharge, mixed with blood, from the nose of a young child nearly always indicated a foreign body; if the discharge were offensive as well, then the diagnosis of a foreign body was almost certain. (2) In removing these foreign bodies, much the best method is to employ a blunt hook, and not forceps, as forceps are apt to push the foreign body further and further into the nose, whereas the blunt hook gets beyond the foreign body and at once pulls it down. This, of course, would apply to round, hard objects, such as buttons, beads, etc., which are the objects commonly found in children's noses.

Foreign Body in the Larynx.

A girl, æt. 19, came among the out-patients with the following history: Two days previously, when taking broth at supper, she felt something stick in her throat, and had a severe attack of choking. She went to visit a doctor, who passed a bougie down the œsophagus without giving the patient any relief. It was then noticed that she had almost completely lost her voice. She was able to swallow water and take some toast. On the next day she again had medical advice, but no relief was obtained, although an emetic was given. A foreign body was discovered by the medical man, who then recommended her applying at the hospital for its removal. On examination the patient was noticed to be in no discomfort whatever. The breathing was natural, there was no cough, and it was only when the girl began to speak that anything wrong was detected. Her voice was very weak and slightly husky. On inspection of the larynx it was seen that there was a foreign body lying inside the larynx in contact with the posterior wall; a white spot was also visible on the anterior wall of the trachea below the vocal cords. The whole larynx was reddened. The pharynx and larynx were painted with cocaine until they were anæsthetic, and the foreign body was extracted with Krause's forceps without any difficulty. It proved to be part of the breast-bone of a chicken. It was a thin plate of bone, triangular in shape, measuring one inch vertically, its horizontal base being a little more than three-quarters of an inch. It had been situated in the larynx as a vertical plane, so as to form a sort of median partition; its median upright position explained why the breathing had not been impeded.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

Pelvic and Subphrenic Abscess.—Mr. Arthur Edmunds operated on an unmarried girl, æt. 20, who ten days previously had been seized with an acute pain in the epigastrium while she was at work. She was compelled to go home and lie up, but the pain was not excessive, and there was no definite collapse. During the ten days preceding her admission into hospital, her symptoms were equivocal; the pain continued with remissions, and the abdomen became gradually distended; there was a slight temperature, and the pulse was quickened. The abdomen at first was generally tender, but for two days before admission the tenderness had become restricted to the hypogastric region. On admission she was seen to be well nourished; her pulse was rapid—about 120; her temperature was about 102°; her tongue was furred. On examining the abdomen, a large swelling could be felt, extending upwards from the symphisis, but not extending into either flank. The abdomen, as a whole, moved poorly with respiration, and was moderately distended. Per vaginam a swelling could be felt bulging into Douglas's pouch. It was obvious that the case was one of intra-abdominal abscess, and the diagnosis, Mr. Edmunds said, lay between three groups of causes: In the first place one naturally considered the possibility of the abscess being due to appendicitis. Here it seemed probable that the appendix was not at fault, for although the pelvic swelling was a very large one, there was not the slightest resistance in the right iliac fossa, and there was no definite tenderness about the root of the appendix. It was also a very marked feature in the case that the pain had commenced in the upper part of the abdomen, and had never concentrated itself on the appendicular region. There was no history of previous attacks, so that, on the whole, it was probable that the appendix was not affected. The diagnosis then lay between a pelvic abscess which had been produced in or around a pelvic viscus, and one which had been infected from a distant organ. The pelvic origin of the abscess was not very easy to understand in view of the intact condition of the vaginal outlet, and taking into account the point of origin of the pain, it seemed probable that the source of the trouble was to be sought elsewhere. In giving an account of her history, the patient had mentioned that she had had occasional vomiting, but it was only later in the case that one was enabled to elicit the fact that she had had slight hæmatemesis. The abdomen was opened in the middle line so as to explore the swelling from above, and it was then found that there was very little wrong with the appendix or any other intra-abdominal organ. Towards the pelvis, however, the intestines were matted together to form the roof of a large fluid swelling, obviously a big abscess. The question now arose as to the best method of draining this. Although it is quite easy, Mr. Edmunds pointed out to drain an abscess across the peritoneal cavity it is by no means desirable to do so when the abscess is so large that any opening into it will be very likely to flood the whole peritoneal cavity with pus. While it is quite easy to sponge up a few drachms of pus in a deep abscess, it is impossible to do so when the contents of that abscess can be measured in pints, and it is much safer to drain through the vagina. Accordingly, the index finger of the right hand was passed into the vagina with a pair of scissors lying flat along its palmar surface, and with some little difficulty the posterior cul-de-sac was opened up. The left hand was kept in the abdominal cavity, so as to form a guide to the forceps, which were afterwards passed up the opening made by the scissors. The blades of the forceps were then separated so as to enlarge the opening, and a large drainage tube inserted, the end of which dipped beneath the surface of a bottle of carbolic lotion. The abdomen was then closed by through and through sutures of silkworm gut, this part of the operation being entrusted to an assistant whose hands had not been soiled by the pus which escaped from the pelvic abscess. The tube acted well, and the abdominal wound healed kindly. The pain was relieved, and the patient's condition improved. In the middle of the third week after the operation, however, she began to have cough and pain in the left hypochondrium, which was made worse by any movement or by drawing a long breath. Signs of fluid manifested themselves, and a needle was put into the chest, with the result that pus was obtained. Accordingly, a portion of the eighth rib was excised and the pleural cavity opened, giving vent to about a pint of clear, serous fluid. On further exploration the diaphragm was found to be pushed up rigid and immovable; this was obviously due to a collection of pus beneath it. It seemed necessary, in view of the infective nature of the case, to drain the pleural cavity as well as the subphrenic abscess. A further portion of rib extending almost down to the costal cartilage was removed, and the wound was divided into two by suturing the diaphragm to the chest wall, and by drawing the muscles together around a drainage tube, which was inserted into the pleura. An opening was then made into the diaphragm from above, about an ounce of pus let out, and a drainage tube passed into the abscess cavity. The patient stood the operation well, and is now making very good progress. The vaginal discharge has almost ceased, and the wounds in the chest wall are healing rapidly. Mr. Edmunds said that in treating such abscesses various methods could be employed, the ideal one being to suture the diaphragm to the chest wall, allowing the pleural cavity to become shut off before opening the abscess cavity, but in the present case it was not possible to do this on account of the large amount of fluid present; and, furthermore, the probable infective nature of the pleural contents made it desirable to drain this cavity, a method of procedure which has the disadvantage of exposing the patient to the risk of further infection from the subphrenic abscess—a risk which, in the present case, has fortunately not been realised.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Clinical Section.

First Meeting held on Friday, October 11th.

Sir Thomas Barlow, President of the Section, in the Chair.

Mr. T. H. **Openshaw** showed a case of Congenital Absence of the Fibula in a boy, æt. 10. The outer half of the foot and the outer two toes were also missing on the same side. There was no similar case in the family. By means of suitable apparatus the boy was able to walk perfectly and to play games. Mr. Openshaw also showed a child six months old in whom both tibiæ were practically absent. He thought that the scar so often present in these cases was due to intra-uterine fracture of the bone. He advised against amputation of legs with this deformity.

Mr. **Douglas Drew** showed a girl in whom, after two arthrectomies for tuberculous disease of the knee, a movable joint had resulted.

Mr. **Drew** also showed a case of Congenital Dislocation of the Patella, which had been cured by operation.

Dr. A. E. **Garrod** showed a woman, æt. 25, who presented multiple nodules of rheumatic origin. She had had rheumatic fever two years previously, but there was no cardiac lesion. The nodules had been present for eighteen months, but had softened somewhat after the use of Bier's treatment; they were present over the metacarpo-phalangeal joints, elbows, and knees of both sides and over one shoulder. Dr. Samuel West had seen several similar cases, and in some, even the worst, there had been no heart lesion present. Sir Dyce Duckworth was familiar with such cases in adults, and had been struck by their long duration. Dr. Bertram Abrahams had seen four cases in adults, and was sceptical about their being always of a rheumatic nature; in some he had followed for years no rheumatic manifestations had developed. He pointed out the remarkable symmetry of the nodules in adult cases, and their greater discreteness. Dr. Poynton had seen in children nodules of long duration. The President agreed with Dr. Garrod's diagnosis. He had found the association between nodules and endocarditis less close in adults than in children. They often lasted over a year in adults.

Mr. F. J. **Steward** showed a child that had recovered after operation for pyopericardium. An empyema had previously been opened at the left base, and the pericardium was opened and drained through this wound. The pus of both was pneumococcal. Dr. West had seen recovery from an anterior opening. He advocated simple incision without thoracotomy. Mr. R. T. Godlee related a case in which Mr. Raymond Johnson had successfully drained a pyopericardium that was secondary to osteomyelitis.

Mr. T. **Hutchinson**, jun., showed a case of Fusiform Aneurism of the Right Carotid Artery in a woman, æt. 63. There was no syphilitic history. Symptoms dated back for 18 months. He proposed to perform distal ligature, as it was impossible to perform this proximally.

Dr. F. E. **Batten** demonstrated a case probably of Cerebellar Atrophy. The patient, a man of 62, had had slight unsteadiness for six years, but had become much worse after an attack three years ago. There was slight nystagmus and marked kinetic ataxy. In the lower limbs the ataxy was chiefly present on walking.

Dr. H. A. **Lediard** showed the case of a man with Diffuse Sarcoma of the Skin. This was most marked in the head, but extended in the trunk to the waist. Sir Dyce Duckworth did not agree with the diagnosis, and advocated treatment by large doses of sarsaparilla.

Mr. **Cecil Rowntree** showed a male patient with a large, probably Myxo-sarcomatous, Growth on the right thigh.

The **President** then delivered his introductory address, in which he reviewed the history and work of the Clinical Society for the forty years of its existence.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Oct. 13th, 1907.

Dilatation of the Stomach.

Dilatation of the stomach is one of the most troublesome affections that a practitioner has to deal with. The treatment is medical, but, above all, dietetic. A proper régime imposed on the patient is of the greatest importance, for without attention to the nature of the food medicine can have but an illusory effect.

The meals should be so arranged that food should not be introduced into the stomach unless the preceding repast has had time to digest. In some cases, says Prof. Lemoine, the organ is very sluggish, so that only two repasts daily can be allowed, one at 10 o'clock in the morning, the other at 7 in the evening. Generally three repasts may be taken, and no drink or food allowed between the meals.

The dry régime is best suited for these patients, as liquids distend the stomach; for the same reason soups should not be absorbed.

The first repast in the morning should consist of tapioca, or one or two boiled eggs with a piece of bread. The two other repasts may be varied in their composition, but vinegar, sauces and grease should be avoided, as well as fresh bread. The solid food may be composed of rice, tapioca, macaroni, roast meat, salmon, fresh cod, vegetables (well cooked); marmalades, jams, all kinds of game, shell-fish, and strong cheese should be excluded.

The medical treatment should have in view the maintenance of the energy of the muscular system. As a nervine tonic, phosphate of soda is of a great value if persevered in for several months:

Phosphate of soda, 4 dr.
Tincture of nux vomica, 40 m.
Syrup of bitter orange, 10 oz.
A tablespoonful an hour before meals

Or, Sulphate of strychnine, 1 gr.
Water, 5 oz.

A teaspoonful in a little water before each meal.

Ipecacuanha in small doses is an excellent stimulant; one-grain pill after meals has been recommended by Mathieu.

Massage of the epigastrium has been practised by Dujardin-Baumetz, and with good results, but it requires to be done methodically, and according to precise rules, and by practised hands. However, it can be replaced by a general massage done each morning in a bathing establishment after a cold douche. When the patients cannot take the shower bath, it can be replaced by rubbing the whole body with a flannel moistened with a mixture of alcohol and turpentine:

Spirits of turpentine, 2 dr.
Spirits of camphor, 4 oz.
Spirits of lavender, 2 oz.

And an alkaline bath twice a week:

Carbonate of soda, 4 oz.
Salt, 2 lb.
(For one bath.)

Washing out of the stomach should be reserved for cases where the distension is considerable, and symptoms of putridity of the contents of the stomach exist.

The food that remains incompletely digested in the stomach accumulates after each meal, and finally undergoes fermentation, provokes the formation of ptomaines, and becomes dangerous for the economy. It is to the absorption of these toxins that may be attributed headaches, vertigo, neuralgia, hepatic colic, etc. In such cases antiseptics are plainly indicated—salicylate of bismuth, salol, betol, naphtol, or benzonaphtol. Laxatives in the form of purgative mineral waters (Montmirail, Châtel Guyon, Rubinat) should be ordered two or three times a week.

Besides the above treatment, the patients should be enjoined to suspend all intellectual work and replace it by physical exercise, manual labour, fencing, gymnastics, bicycle riding, etc.

INJECTIONS OF THIOSINAMIN.

Within the last few months the virtues of thiosinamin are being spoken of after many years, during which it had fallen into oblivion. It is now being employed in sclerous affections, such as pleuretic adhesions, chronic perigastritis, stricture of the urethra, the œsophagus, and the affections of the middle ear (sclerosis of the tympanum).

Two patients were recently treated for stenosis of the pylorus following gastric ulcer. Every three days 20 drops of a solution of thiosinamin (1/10) were injected. At the end of three weeks considerable improvement took place. In another case of ankylosis of the knee, mobility was restored by daily injections of the same solution, to which was added salicylate of soda.

GERMANY.

Berlin, Oct. 13th, 1907.

AT the Free Society of Surgeons, Hr. Nordmann showed a case of

INTRAPERITONEAL RUPTURE OF THE BLADDER.

A waiter was wounded whilst in a state of drunkenness. He had a constant desire to pass urine, and in the course of 24 hours showed signs of peritonitis. A catheter was passed, and a large quanitity of urine drawn off, which was afterwards found to come from the peritoneal cavity. He concluded that the case was one of perforated gastric ulcer, and made an opening into the upper part of the abdomen, but found that the stomach was whole. He then opened the lower part, and found a rupture of the bladder. The parts were united without drainage, and recovery took place.

Hr. Martens spoke on the technique of

OPERATIONS FOR PERFORATED ULCERS OF THE STOMACH.

He felt himself bound, he said, in cases of perforation peritonitis, when too much time had not elapsed, to open the abdomen, whether ulcer of the stomach with perforation could be diagnosed or not. It did not do to wait for the shock. The patients were given saline infusions, and were operated on under general narcosis.

At the operation the aim should be to find the perforation as quickly as possible, and close it. It was enough to stitch it over; at the most the edges might be freshened. Omentum was adjusted over the sutures. It was only advisable to add gastroenterostomy if the ulcer was situated on the pylorus, and this was narrowed by the sutures. It only became a question of jejunostomy when the ulcer was very large, and it could not be closed by the sutures.

After completing the suture the abdomen was thoroughly washed out with saline solution, of which 20 to 30 litres were made use of. He kept on with the washing out until all stomach contents were washed out.

The abdomen was closed up to a small opening for drainage, but no tampon was left in. He had had the leucocytes counted in his cases, but the results obtained were not constant.

Hr. Federmann, on the other hand, laid stress on the counting of the leucocytes both for diagnostic and prognostic purposes, and thought it advisable to leave out the washing out of the abdomen.

Hr. Körte was of opinion that early diagnosis was easier than after 15 to 20 hours, when the peritonitis had become fully developed, and the whole abdomen equally tender. He had now operated in 20 cases, of which 6 had died. The prognosis was not so unfavourable if the operation was performed within the first 24 hours. Washing out was unconditionally to be recommended. It was, without doubt, the most non-irritating way of cleaning out the abdomen. After that it was best to close up entirely. It was to the purpose also to add gastroenterostomy to the closure of the ulcer.

Hr. Martens related three cases of

PYLEPHLEBITIS COMPLICATING PERITYPHLITIS.

One of the cases was remarkable in that thrombosis of the portal vein occurred, although the appendix was removed within 40 hours of the commencement of the attack. In general, however, pylephlebitis was more rare since the introduction of early operation.

Hr. Körte confirmed what had been said, and had seen a case in which the patient died of pylephlebitis, although the operation was performed within the first 24 hours.

Hr. Israel had seen a patient who from an error of diet had a rigor, and died in three weeks from constantly recurring rigors, jaundice and swelling of the liver. The autopsy revealed multiple abscesses of the liver, pylephlebitis, a quite small ulcer on the vermiform appendix, and at the base of it a thrombosed vessel.

Hr. Engelmann showed a patient with

ACUTE INFLAMMATION OF THE PANCREAS.

He was admitted into hospital with symptoms of general peritonitis, great tenderness over the upper part of the abdomen, which projected forwards, and showed dulness on percussion. Recovery took place after clearing out the exudate and drainage of the bursa omentalis. The next case was one of rupture of the liver from compression. The torn part was united by suture. Some time afterwards a subphrenic abscess formed, which was opened. Recovery took place.

AUSTRIA.

Vienna, Oct. 13th, 1907.

POLYNEURITIS AND BACTERIUM COLI.

CHOROSCHKE has been devoting his attention to parenchymatous and interstitial polyneuritis, and finds that many parenchymatous cases have clinically every appearance of interstitiæ. The absence of fever and the long-continued course of the disease declare it to be a toxæmia. Whence comes the infection? he asks; and answers—from the bowel; it makes its way into the urinary tract, which he considers the most favourable for its transmission. The narrowing of the lumen of the bowel, which produces a coprostasis higher up from the poison of the bacterium coli, which wanders from the bowel through the atrophied gastric wall, and thus makes its way to the bladder by the peritoneum, in which red stripes can be traced in the post-mortem room, clearly demonstrates the mode of passage. In consequence of the long retention of the fæces in the bowel, the bacterium becomes more virulent, and thus easier cultivated in the urinary tract, where any slight lesion admits of a ready absorption into the blood. This he considers the real cause of so many cases of meningitis and myelitis being associated with the bacterium coli, and from this attack on the meninges reasons that coprostasis produces polyneuritis, from which the toxin of the bacterium can equally be obtained with the same readiness.

ATOXYL IN RELAPSING FEVER.

Glaubermann has been using atoxyl for some time with the best results, but it must be given in larger doses than the prescribed orthodox quantity. He treated 30 cases with small doses, but did not obtain the effects expected. He tried 40 other cases with doses of 9.0 to 23.0 cubic centimetres of a 20 per cent. solution. In seven to fourteen days the fever disappeared.

He considers this a reliable drug in relapsing fever, shortening the pyrexia by three days.

Origin of Cancer.

At the "Naturforscher," Prof. Kelling again advanced his theory of the origin of cancer by the implantation of embryonic cells, which he considers are taken in as foreign bodies in the nutrition, and under certain conditions are absorbed through slight lesions in the mucous membrane. As further proof he exhibited the blood serum test in carcinomatous patients. This is conducted with the albumin of the foreign embryonic cells, where the mixture produces a cloudy condition, or in others a rapid solution of the blood corpuscles. In 265 experiments half of them were positive, while 28 of these reactions positively negatived the diagnosis of cancer, and which were operated on with perfect success. He disputed Dungern's results on the ground of absent control experiments.

Curious Crystal.

At the same meeting Dr. Mayenburg exhibited a gigantic crystal of the chromate of alum which he had grown from the size of a pin's head to half a metre in the course of 24 years. The small crystal he commenced with was kept in a saturated solution, cold, of the same substance, and throughout its growth retained a beautiful octahedral form. The crystal weighed 42.5 kilogrammes, or 85 lbs.

Female Structure.

Prof. Schultze, in his anthropological research, affirms that the female in structure is more child than man, and refers to the plastic form of the skeleton and the formation of the muscular, fatty, and pigmentary parts, as well as the proportion of the face. The legs are relatively short, while the body is large. He maintains that the greatest disproportion exists in the head and body, the female brain being absolutely lighter, while the child's is relatively heavier than the male. The finer skeleton of the face, the form of the lower maxilla, and the simplicity of the cerebral surface, are distinguishing features of the female. The smallness of the throat and greater size of the thyroid, lung, heart, liver and spleen, with different construction of blood and stomach, are other adjuncts. The cause of this juvenile condition is not due to any depression by the male, want of culture, etc., but is rather due to the phylogenetic progression of the male.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Teaching of Clinical Surgery in Edinburgh.—A scheme for the improvement of the teaching of clinical surgery in the University of Edinburgh has been promulgated by the University Court, and will probably come into speedy operation. It is proposed that the ordinary surgeons to the Infirmary, except the surgeon teaching women students, be invited to become University lecturers on clinical surgery, on condition that—(1) Each lecturer acts as an examiner on the same terms as the professor of clinical surgery. (2) As in the case of other lectureships, 75 per cent. of the fees to be paid to the lecturer. (3) The University Court provides a sum to each lecturer which will cover the salary of a clinical tutor. At present the students divide themselves unequally among the different teachers of surgery, and one of the circumstances which influences the distribution is the fact that only one of the surgeons, as a rule, is an examiner. Not unnaturally, this leads to his clinic being unduly crowded, and prevents the whole clinical material of the hospital being used to the best advantage. The plan of the Court is a simple way of remedying this, and it is to be hoped that it will be accepted by the ordinary surgeons. If it comes into force it will also have the advantage of shortening the period over which the examination in clinical surgery extends. Each lecturer will, of course, receive the whole fees of the extramural students attending his class, as well as the proportion of the fees of University students.

Edinburgh Royal Infirmary.—Retirement of Dr. Alex. James and Mr. Chas. McGillivray.—At the usual weekly meeting of the Board, a resolution in appreciation of the services of Dr. Alexander James was passed by the managers. They "fully realise, and highly appreciate, the assiduous and constant attention he has paid to the patients under his care, and the great success which has attended his labours, and they are well aware that his skill as a teacher of clinical medicine has been shown by the large number of students who have taken advantage of his instruction in the wards under his care. By his kindly and considerate manner to all with whom he came in contact, by his great ability, and by his unwearied devotion to duty, he has endeared himself to his patients, his students, and his colleagues. In parting with Dr. James, the managers offer him their heartiest good wishes, and as a testimony of their esteem for him, appoint him one of the consulting physicians to the Institution." A similar recognition was paid to Mr. C. W. McGillivray for his services as one of the acting surgeons for the past fifteen years. The managers appointed him one of the consulting surgeons of the Institution.

New Physical Laboratory, Edinburgh University.—At the beginning of the winter session, next Tuesday, the physical laboratory will be transferred to the new buildings, which consist of the reconstructed surgical hospital of the old infirmary. The main walls of the building have been retained, but the wooden flooring has been replaced by concrete on steel girders, running east to west to avoid magnetic disturbances. On the principal floor is the lecture-room, a library, and a reading-room. The arrangements for demonstrating experiments during lectures are very complete. Under the lecture table there is a room for manipulating boilers, gasometers, and other bulky pieces of apparatus, and the blackboards, etc., slide down into this room. The lantern is set in a gap in the lecture table, and its rays are reflected by a mirror on to a screen which is equally visible to all the students. Above the ceiling over the lecture table is an attic, the floor of which has openings for experiments with long pendulums, falling bodies, etc., and a drop of 45 ft. can be obtained. The whole department has been reconstructed by Sir Rowand Anderson and Mr. Balfour Paul, architects. They have been advised by Professor Macgregor, who has made a careful study of the most recent and complete laboratories on the Continent and in America.

Consumptive Sanatorium for Ayrshire.—As a result of a conference between the various local authorities in the county, the Chairman of the Glenafton Consumption Sanatorium has offered to hand over the sanatorium to the county as a free gift provided the county give opportunities for treatment at least as great as the Ayrshire Association does at present. A report to the Ayr District Committee from Dr. Macdonald showed that to meet the county's needs there would require to be provided 80 beds, which would involve the enlargement of the present sanatorium at a cost of £6,000, and a subsequent charge for maintenance of about £3,600. It was agreed to send down this information to the various local bodies concerned.

Complimentary Dinner to Dr. MacPhail, Glasgow.—The occasion of this function was the departure of Dr. MacPhail from St. Mungo's College to take up the post of Lecturer on Anatomy at Charing Cross Hospital. Professor Cleland presided over a large gathering, and the toast of the evening was proposed by Dr. Gemmell, and afterwards Sir John Ure Primrose presented Dr. MacPhail with a chronometer, a dissecting microscope, and a number of books.

BELFAST.

Report of the Medical Officer of Health.—The report on the health of the County Borough of Belfast for 1906, just published, is of special interest, as it is the first report issued by Dr. Bailie, over whose appointment last year there was so much excitement. It is only fair to him to bear in mind that he was in office for just two and a half months of that year, and that many details which he might wish to include in the report were not to be obtained. But in spite of this, the report shows a very marked improvement on all previous ones, which year after year have been commented upon in these columns. It is a well printed and bound volume of nearly 200 pages, with four maps and eight charts and a good index. It is, indeed, pretty clear that Dr. Bailie has read and taken to heart the comments on the former reports. The report opens with a summary of the vital statistics for the year 1906, showing a population of 366,000, a birth-rate of 31, a death-rate of 20, a zymotic death-rate of 2.5, a phthisis death-rate of 2.7, and an infantile mortality of 143 per 1,000 births. There are two clear charts giving the total deaths at various age periods, and the principal causes of death. An interesting article on the population of the city shows that according to the Registrar-General's figures it was last year 366,000, but according to other calculations it was as much as 394,000. Calculated from the number of houses inhabited it was 388,000. The first four tables deal with zymotic disease and notifications, then several tables are devoted to phthisis. A study of the birth-rate shows that while it has fallen the fall is only trifling compared with many other cities. It was 31 per 1,000, as compared with an average of 31.7 for the previous ten years. The rainfall in Belfast is put at about 36 inches, but this hardly does justice to the city, for it is taken at the Antrim Road Water Works, where the fall is increased by the proximity of the hills. If taken in the centre of the city, or on the south or east side, it would probably be decidedly less. Table No. 11 gives the names of the dispensary medical officers, the population of their districts, and the number of cases of phthisis, whooping-cough, and measles voluntarily notified by each during the year. Generally speaking, the number of cases seems to be about inversely proportionate to the age of the medical officer! Typhoid has an article of 29 pages in length devoted to it, giving a history of a recent outbreak, and its connection with the milk supply—a very instructive report already given in some detail in this column a year ago. Table 15 shows that only nine cases of typhus were notified, with three deaths, a great improvement on many former years. Scarlet fever was prevalent, but the mortality was only 2.17 per cent. Diphtheria also was prevalent, and showed a mortality of 17.6 per cent. Two pages are given to disinfection, and details of the method and cost are given. Attention is being paid to books belonging to the Public Library in houses where infectious diseases had occurred. The subject of infant mortality is not as fully discussed as one could wish, and it is to be hoped that Dr. Bailie will devote much more than three pages to it in his next report. The rate in Belfast was 143 deaths under one year old, per 1,000 births, and a table is given showing the rate in a number of large towns, all of which, except Glasgow, are worse than Belfast. But we are not informed why these particular towns were selected, and we notice that London, Bristol, and Nottingham, for instance, are not included in the list. About twelve pages are given to the important subject of phthisis, and the views expressed are on the whole satisfactory. They show to a marked extent the influence of the late Belfast Health Commission, but are none the worse for that. The card of instructions for consumptives, which is distributed freely in the city, is re-published at length, and brief particulars are given of the work done by the various hospitals in combating the disease. There are five female inspectors engaged as health visitors in the city, and of the 13,000 visits paid by them last year 1,300 were to cases of phthisis. After a short notice of the water supply, seven pages are devoted to a consideration of the milk supply and questions connected with it. The gist of the article is that far wider powers are needed by the authorities if they are to deal satisfactorily with the difficult problem of infected milk. For several years past we have been asking for particulars as to prosecutions for adulteration of foods, etc., and now at last we get them. We find that 1,563 samples of foods and drinks were taken for analysis, and 67 were found to be adulterated. There were 61 prosecutions and 51 convictions, the fines amounting to £85. It is a pity we cannot have another table giving an estimate of the profits of undetected adulteration! The seizures of unsound food are also given, chiefly shellfish and fruit. Another table gives the number of pigs kept in the different districts of the city, and it is rather startling to find that the total is 2,770. The summary of the proceedings taken for the abatement of nuisances and the work done is most interesting, as is also the account of the public abattoir, in which 58,000 animals were killed and 179 seized as unsound. Ten pages are given to the work of Professor Symmers at Queen's College in examining specimens bacteriologically, a work the great interest of which merits separate notice, as it includes a careful examination into the bacteriology of the shellfish of Belfast Lough. The report ends with a good index and maps showing the localities in which the principal zymotic diseases occurred. As we said at the beginning, the report is a marked advance on its predecessors, and includes almost every point to the omission of which attention was called in former years. One thing is still omitted, and that is an account of the working of the refuse destructor. No doubt this is a concession to the feelings of some of Dr. Bailie's former colleagues on the City Council, who were responsible for the erection of this costly failure.

LETTERS TO THE EDITOR.

MEDICAL LAW AND QUACKERY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—My letter of last week, in which I called attention to the weakness of medical laws as compared with the Veterinary Act, has drawn forth an interesting private communication from a distinguished F.R.S. professor of biology at a British University, from which I am permitted to publish the appended excerpts. If the profession propose to fight the battle of medical law reform with the necessary determination, it may be desirable sooner or later to discuss the question of getting proper representation in Parliament. One or two men with the power and will to make their voices heard might accomplish much; and if the sacrifice of time and income were too great to be conceded gratuitously, it would pay the profession to provide adequate incomes to members willing to devote themselves to political life. My friend writes:—"There can be no doubt that, both in the House of Lords and House of Commons, there are many men so ignorant of the whole field of biological science that they cannot understand the aim or necessity of the education that the qualified man has to pass through. I believe the root of the difficulty lies in the system of education in our higher public secondary schools, in which science is still stigmatised as 'stinks,' and which turn out as 'educated' men boys to whom the whole range of science is as a closed book. These men go into Parliament and public life not only ignorant of science but with an unveiled contempt for us. To their stupid brains the medical man is a kind of 'stinks' man, and ought to be treated with contempt. It is a pity that the medical graduates of some great University cannot unite to run a candidate for their seat irrespective of party politics, with a mandate to look after medical legislation. The doctors who do get into Parliament are mostly so bound by party ties that they cannot do much to promote medical Bills."

I am, Sir, yours truly,
HENRY SEWILL.

October 12th, 1907.

P.S.—Since writing the above, I have seen in the *Times* of to-day the full summary of Mr. Beale, the Australian Royal Commissioner's report, to which you refer in your editorial notes. If a single lay Commissioner with scanty powers can produce a solid indictment of quackery such as Mr. Beale has constructed, what might not be achieved by a Royal Commission armed with full powers, including the power to compel the attendance of witnesses and examine them on oath? In the papers of to-day appears also the news that in Germany there comes into action this month a law which, if administered with only a part of the zeal always displayed in matters affecting the welfare of the people of the Fatherland, will put an end at once to the traffic in fraudulent quack medicines and apparatus, and to the illicit practice to which that traffic serves everywhere as a cloak. What has been done in Australia and Germany can be done in these islands, and it will be done so soon as the profession unites to carry the matter through with unflinching courage and determination. H. S.

CONGENITAL ANOMALIES OF THE EYE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. J. Herbert Parsons must allow me to thank him for his courteous correction. What he said in his recent and admirable work on "Diseases of the Eye" was clear enough. But, unfortunately, some imp of mischief not wholly unconnected with the printer's office changed the "neuritis," as I originally passed the word, into the "pseudo-neuritis," as actually printed in the columns of THE MEDICAL PRESS AND CIRCULAR. I am glad to find that so competent an authority as Mr. Parsons is in accord with me in thinking that probably the optic disc is never abnormally swollen in pseudo-neuritis. Although it often appears to be so, I have never satisfied myself that such is actually the case.

I am, Sir, yours truly,
SYDNEY STEPHENSON.

33 Welbeck Street, W., October 13th, 1907.

AN APOLOGY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I write to you to say that, through no fault of mine, a sensational account of a lecture by me has appeared in the general Press. I see to-day extracts from it put together as if it had been an interview.

I cannot describe how profoundly sorry I am that this discreditable sensation has occurred, and wish to tender my humblest apologies through your medium to all members of my profession. I may hold singular individual views, but I have no desire to ventilate medical matters through the lay Press.

I am, Sir, yours truly,
BERNARD HOLLANDER.

35A Welbeck Street, Cavendish Square, W.,
October 10th, 1907.

[Of course, we publish Dr. Hollander's disclaimer, but we think it should be possible to prevent the publicity which his lectures obtain. As in at least one lay paper a photograph of Dr. Hollander appeared, it would seem that his friends are particularly apt to compromise him in the eyes of his colleagues.—ED.]

The following letter, addressed to the *Irish Independent*, may be of interest to our Irish readers:—

SIX BROTHERS DOCTORS.

SIR,—It would appear from your issue of yesterday that the Earl of Kilmorey, when distributing the prizes at the opening of the medical school at Charing Cross Hospital, felt surprised at learning that there are at present five brothers doctors. I daresay his lordship will be more surprised to hear that the late Dr. Macnamara had the pleasure of living to see six of his sons doctors, all making their mark:—Dr. G. M. Macnamara, who represents his father; Colonel John Macnamara, I.M.C.; Colonel William Macnamara, I.M.C.; Major M. Macnamara, I.M.C.; Major Robert Macnamara, I.M.C., who was appointed lately Inspector of Prisons out in India, and though last, not least, Dr. Joseph Macnamara, who has a very extensive practice in London. They are a credit to their name and country.

JOHN KERIN.

Corofin, County Clare, Oct. 3rd, 1907.

THE twentieth Congress of the French Surgical Association was opened in the great amphitheatre of the Faculty of Medicine in Paris on the 7th inst. The question for discussion was the influence of Röntgen rays on malignant tumours. Many well-known surgeons were present and took part in the discussion.

OBITUARY.

E. A. WRIGHT, M.D.EDIN., of Huddersfield.

WE regret to announce the death of Dr. Edward Arthur Wright, formerly of Huddersfield, which took place last week at Clevedon, Somerset. He had suffered from a painful malady, for which he underwent an operation about a week before. The deceased, who was 58 years of age, was the son of a Cheltenham clergyman. Entering upon a medical career, he became M.B. and C.M. of Edinburgh. In 1875 he was appointed assistant house surgeon at Huddersfield Infirmary. After holding that position for about two years, he commenced practice for himself, and in 1892 he was appointed one of the honorary surgeons at the Infirmary, and continued in that position until April 10th, 1905, when he resigned in consequence of ill-health, arising partly from injury received in a trap accident, but mainly from successive attacks of influenza. In consideration of those services, on July 28th, 1905, he was appointed honorary consulting surgeon to the Infirmary.

GEORGE FREDERICK ELLIOTT, B.A., M.D., F.R.C.P.

MUCH regret will be felt at the death of Dr. George Frederick Elliott, one of the highest esteemed members of the medical profession in Hull. The deceased gentleman, who had attained the ripe age of 73 years, died on the 6th inst. The late Dr. Elliott was the second son of Mr. William Elliott, of Strabane, County Tyrone, who was a member of the younger branch of the Elliotts of Cavan. An ancestral head of this family, Sir John Elliott, settled in Cavan, and was created a baron at the time of the Ulster rebellion in 1604. The deceased held the degrees of M.D. (Dublin), F.R.C.P. (England), and B.A. (Oxford). Upon qualifying as a physician he entered the Royal Navy, being attached to the medical staff of the first branch of the Imperial forces for eight years. Subsequently deceased held appointments at the Haslar Hospital and at the Melville Marine Hospital, Chatham. About forty years ago he came to Hull, where he rapidly acquired a practice of no ordinary proportions, for it extended into Lincolnshire. He was appointed physician to the Hull General Infirmary, as it was then called, in 1867, and, at the same time, lecturer on medicine at the Hull Medical School. When the present Convalescent Home at Withernsea was opened by Sir James Reckitt, Bart., he was appointed consulting physician. The late Dr. Elliott took no part in public life, being of a very retiring disposition. Deceased leaves a wife, one daughter, and four sons.

HENRY STOLTERFOTH, M.A. CAMB., M.D. EDIN.

WE regret to record the death of Dr. Henry Stolterfoth, which took place at Grey Friars, Chester, on October 4th, after a protracted illness. The deceased gentleman was a victim of that insidious disease, cancer, and had been constantly attended by Dr. Taylor. By his death Chester has lost one of its most useful and genial public men. Dr. Stolterfoth was educated at the King's School, Cambridge, and entered Gonville and Caius College, Cambridge, in 1856. He took honours (sen. opt.) in mathematics in 1859, and gained his M.A. degree in 1863. In 1868 he graduated M.D. at Edinburgh, and was awarded a bronze medal for chemistry. He then settled in practice at Chester, and took great interest in public affairs. In November, 1892, he was unanimously elected Sheriff, and six years later was installed in the mayoral chair in recognition of his public services. During his year of office the question of the amalgamation of Hoole with Chester engaged the attention of the City Council, and the Isolation Hospital at Sealand was opened. As a medical man and member of the Public Health Committee, Dr. Stolterfoth took a keen interest in the consummation of the latter scheme. He was connected with the Infectious Hospital at the Infirmary ever since its erection—a hospital which, he once said, had been of incomparable use to the city. In 1891 Dr. Stolterfoth was elevated to the magisterial bench, and in 1900 his colleagues on the Town Council conferred upon him the rank of Alderman. The deceased gentleman was one of the first to come in contact with the Rev. Charles Kingsley in connection with the formation of the Chester Society of Natural Science in 1871. He was a Liberal in politics and regularly appeared on the party platform, but there was no element of party bitterness in his nature, and he was highly respected both by political friends and opponents alike. He was seventy-one years of age, and leaves a widow but no family.

SPECIAL ARTICLES.

THE TUBERCULOSIS EXHIBITION IN DUBLIN.

The Tuberculosis Exhibition, which has been organised in Dublin by the Women's National Health Association, under the presidency of Her Excellency the Countess of Aberdeen, was opened last Saturday by His Excellency the Lord Lieutenant of Ireland, among the others taking part in the ceremony being the Chief Secretary (Mr. Birrell, M.P.) and Professor Osler. In declaring the Exhibition open, His Excellency read the following telegram from His Majesty the King:—"I am commanded by the King to express his good wishes for the success of the Tuberculosis Exhibition, the first of the kind ever held in Great Britain and Ireland, on the occasion of its being opened by you. His Majesty is greatly interested in the problem of checking the progress of this disease, and he trusts the Exhibition may be the means of directing attention of the public to the terrible ravages caused by this scourge and to the efforts that are now being made to arrest its progress."

Prior to the opening of the Exhibition the Consultative Committee had met in conference, and expressed warm approval of the arrangements made by the Executive Committee, while on the previous evening Professor Osler, M.D., had delivered an introductory lecture in the theatre of the Royal Dublin Society on the subject, "What the public can do in the fight against tuberculosis." Dr. Osler referred to the victories that had been won by sanitary service in the case of typhus, of malaria, and of typhoid fever, and held out hope for similar results in the case of tubercle. He said that the ground was prepared for tubercle by three bad habits, bad food, bad air, bad drink. He urged as practical measures the reorganisation of the public health service, compulsory notification of the disease, better housing of the poor, the erection of cheap sanatoria, and care of cases at home by district nurses.

In the Exhibition the exhibits are divided into four sections, the first, which supplies statistics showing the rate of mortality resulting from tuberculosis in different countries, being in charge of the Registrar-General. Diagrams are exhibited in this section illustrating the position which Ireland occupies among different countries with respect to the disease. Some of these diagrams show that, as compared with England and Scotland, Ireland's position is most unsatisfactory and discouraging. Thus, it is shown that whereas the death-rate from tubercle has diminished by nearly a half in England and Scotland during the past forty years, in Ireland it has shown a slight increase. Moreover, in Ireland the age incidence shows that the disease is most fatal in early adult life, the most productive period from an industrial point of view. The deaths from tuberculosis in Ireland in 1906 amounted to 11,756, a figure much in excess of the gross number of cases of mortality resulting from any other disease in that year. Of every hundred deaths from tubercle seventy-six were caused by phthisis. Statistics show that Ireland holds fourth place with regard to this disease among the British possessions and foreign countries. Maps specially coloured to throw into relief the parts of Ireland where tuberculosis is most prevalent show that the cities and urban districts are the most affected. No less interesting is the second section, devoted to pathology, human and veterinary. The exhibits in the first branch have been collected by Professor M‘Weeney, the greatest pathological or bacteriological expert in Ireland; and in the Veterinary Branch the exhibits are provided by the Royal College of Veterinary Surgeons of Ireland. In this are shown models prepared by Dr. Bermingham, of Westport, illustrating tubercle bacilli in the human sputum, when stained with aniline dyes and strongly magnified. These models are extremely beautiful for demonstration purposes, and will naturally attract much attention. They are an excellent representation of the appearance of the field of a microscope when examining a well-stained specimen of tubercular sputum. In this section are also shown slices of tubercular organs, both human and bovine, together with cultures of the tubercle bacillus.

The Appliances Section consists of a display of spitting cups, handkerchiefs, etc. A novel feature is the display of turf sods, hollowed out to act as spittoons, which can be burned after use. The idea is an excellent one.

Outside there are sleeping bungalows (models), or châlets, designed by Messrs. Kennan and Sons, and also by the contractors for the building of the Exhibition. There is also a sanatorium in the grounds. In the village hospital there is a screen, designed by Messrs. Smith and Sheppard, Dublin, to protect the body of a consumptive patient when the head is below the open window and to receive the pure air. The screen is quite an ingenious thing, for, while it provides that the body of the patient may be kept quite warm, the head and face may be exposed to the sun and air.

The Literary Section, under the control of Dr. Alfred Boyd, is of the utmost importance, particularly to members of public health authorities, and to medical officers of health, since it shows what has been done by municipal authorities elsewhere in the campaign against tuberculosis. Most notable is the exhibit from the borough of Northampton, where, under the executive control of Dr. James Beatty, the death rate from phthisis has been reduced to the extraordinarily low figure of 0.87 per 1,000. There are also tables which deal with the question of infection, segregation, and treatment of consumption, while the relations existing between overcrowding and mortality in the London district are shown by a series of diagrams constructed by Sir Shirley Murphy, Medical Officer of Health to the London County Council. Large diagrams, procured by the Public Health Department of Birmingham, show the industrial occupations in the death-rate from consumption. In that city, and in Sheffield, the system of compulsory notification—it is voluntary everywhere else, these cities having got special Parliamentary powers to enforce compulsory notification—is dealt with. In Manchester the system of milk inspection, as regards city dairies and milk arriving from the country, is shown by a selection of forms. There are also exhibits from Dublin, Belfast, Edinburgh, Bristol, Glasgow, Liverpool, Cardiff, Brighton, and New York. A number of popular pamphlets dealing with tuberculosis are shown, and an interesting feature to those caring for the history of the subject is the valuable collection of medical works lent by Dr. Kirkpatrick.

In the Domestic Section, arranged by Dr. Ella Ovenden and Dr. Lily Baker, are exhibits of milk sterilisers, etc., while demonstrations on invalid cookery are being given each day.

A series of popular lectures is also being given daily, among the lecturers this week being the Registrar-General, Dr. Bermingham, Mr. Lintargin, and Professor Lindsay.

The whole exhibition reflects credit on the Executive Committee, and particularly on the honorary secretaries, Mrs. Rushton and Dr. Alfred Boyd.

THE LONDON MEDICAL EXHIBITION.

The third of the series of Medical Exhibitions, organised by the *British and Colonial Druggist*, has achieved a no less signal success than that of its predecessors. From the day of its opening, on October 7th, to the last hour of its existence, on October the 11th, it was a centre of attraction for a constant succession of medical practitioners. The excellence of the general organisation was well supported by the variety and novelty of the numerous exhibits, which included drugs, foods, instruments, invalid furniture, and a heterogeneous collection of things interesting to those engaged in medical practice. In the present notice it will be possible to mention only a few of the most important exhibits. So far as genuine novelty is concerned the first place may perhaps be allotted to novocain, introduced by the Saccharin Corporation. It need hardly be remarked that the special interest attached to this drug is due to its superiority over cocaine as a non-irritant and non-toxic local anæsthetic. The most important application, however, is in the production of spinal analgesia, which bids fair to revolutionise the field of general anæsthesia for surgical purposes. The adjoining stall of Meister Lucius and Bruening contained a number of interesting synthetical and other products, such as lumenol-ammonium (an antiseptic), holocain, orthoform (local anæsthetic), and various tuberculins. Messrs. Brand, as befits a firm of their reputation, had a stand excellently equipped with invalid soups, jellies, peptonised foods, and other preparations of the kind. The International Plasmon Company showed a series of their well-known products. Cadbury Bros. were well represented, and the Angier Chemical Company were well in evidence with their famous emulsion, to which they have added a throat tablet. Mr. George Back held a popular stall, in which he exhibited samples of his famous diabetes whisky. A prominent feature was Messrs. Baillière, Tindall and Cox's books, which occupied a commanding position in the hall; amongst other well-known volumes we noticed Stewart's "Physiology," Jellett's "Midwifery," Macnaughton-Jones' "Diseases of Women," Rose and Carless' "Surgery," and Walsh's Röntgen Rays." The Equipoise Company showed their most ingenious and handy couches and beds, which are so contrived as to adapt themselves automatically to the movements of a patient's body; they have only to be seen to be appreciated. Messrs. Fairchild and Co. had a striking exhibit of their famous digestive products, including the original trypsin preparations, about which so much has been heard in the treatment of cancer. Messrs. Knoll and Co. showed samples of their fine chemicals, notably styptol (for uterine hæmorrhage), santyl (a non-irritating santal preparation), and the well-known diuretin. Messrs. Armour and Co. had an elegantly arranged stall; their pepsin and other digestive products were shown, together with various suprarenalin, red marrow, cerebrin, and other organic drug products, including notably one of thyroid elixir. Messrs. Christy and Co. had a large and well-filled stall: amongst its many attractions was the novelty "Anasarcin," which is claimed to have an excelling virtue in cases of dropsy: this firm also shows a convenient and cheap electric lamp fitted with mirrors for throat work. Their glyco-thymoline is too well-known to need more than passing mention.

Messrs. Ingram and Royle showed specimens of the numerous spa and other waters of which they are proprietors or agents. Possibly one of the best stalls in the Exhibition was that of Parke, Davis and Co., which it would be hard to beat for the variety, novelty, and excellence of its exhibits. Space does not permit us to do more than mention the typhoid agglutinometer, a cheap and handy method of performing the Widal test without a microscope. Their germicide soap is excellent, and their digitalone, formidine, iodalbin and petroleum emulsion are deserving of close attention.

Jeyes' Sanitary Compounds Company had all their excellent preparations of cyllin, one of the best modern disinfectants and germicides, well arranged on a handsome stall. Zimmermann showed such specialties as urotropin, Beta eucain, argentamine, iodol, and orexin. Messrs. Merck had a number of valuable pharmaceutical preparations, including iodopin, dionin, styptican, and veronal. Messrs. Nestlé and Co. showed their Milo food, which is modified by the omission of starch from their former preparation. They also have a most excellent product issued under the name of "Ideal milk in bottles." Messrs. Peek, Frean and Co. exhibited their new and admirable Tillia biscuits. Messrs. Allen and Hanbury had a peculiarly attractive display of instruments and appliances, amongst which may be noted the pocket urine testing cases, and a good syringe for novocain. The Miol Company exhibited their particular product, which is a good combination of cod-liver oil and malt; Bovril lozenges, essences, and invalid Bovril were well represented, as well as their hardly less important preparation Virol. Wright's Coal Tar Soap, a household word in medicine, was well displayed. Messrs. Martindale had a very large collection of drugs, preparations, appliances, and instruments, many of them of a novel and interesting kind. Their list was headed by their world-famed "Extra Pharmacopœia." Friedrichshall water was of course on show, as one of the oldest and most popular of its class. The Charles H. Phillips Co. showed their well-known milk of magnesia and phospho-muriate of quinine compound. Antiphlogistine was well to the front in the stall of its enterprising proprietors, the Denver Chemical Co. Lastly, Defries and Sons showed the Pasteur and other modern filters, as well as some good disinfectors. On the whole the Exhibition may be regarded as a convenient means of acquiring a good deal of liberal education in many practical medical matters.

REVIEWS OF BOOKS.

DERMATOLOGY. (*a*)

This volume includes some thousand pages of crown octavo size, illustrated by numerous excellent photographic reproductions. It forms one of the most serious American contributions to dermatology that we have seen for some years. On every page it bears the stamp of scholarly handling and of wide information and practical knowledge. The anatomy and physiology of the skin, and the principles of its general etiology, pathology, symptomatology, and treatment are somewhat fully dealt with. In speaking of the drug rashes the author remarks that:—"If these various rashes can be produced by drugs, it is not difficult to conceive of analogous eruptions resulting from other toxic substances." That view was advanced by Walsh in this country at least fifteen years ago under the name of "Excretory Irritation." Dr. Pusey has also advanced that writer's illustration of the finding of bromine and iodine in corresponding rashes and other views. The account of urticaria is adequate, yet concise, and the author justly states that diagnosis of the condition is the smallest part of the problem, the chief difficulty being the determination of the causative factor. In the discussion of alopecia areata and universalis, curiously enough we find no allusion to the relation of that condition with myxœdema and Graves' disease. In the brief space at command, however, it is clearly impossible to take more than a general survey of so great a mass of carefully collated and edited matter. We may therefore say that in our opinion this book will be found of value to all who wish special information in diseases of the skin. It is written in a clear and pleasing style, and is thoroughly well edited. A last reference may be made to the 368 illustrations, which are among the best of the kind we remember to have seen in any work upon dermatology

DISEASES OF THE LARYNX. (*b*)

This short work is worthy of commendation, as it is one which can be placed in the hands of senior students and members of post-graduate classes. The arrangement is excellent and the drawings are good, and as the author in the preface says, "the intention has been to picture the more typical appearances as an aid to their recognition and diagnosis." The illustrations of instruments are useful, as those in everyday use are portrayed, not as is so often the case those of a byegone generation. A short but good account of the newer methods of examination such as "Bronchoscopy" is introduced, and the description of the commoner operations are lucid.

(*a*) "The Principles and Practice of Dermatology." By Wm. Allen Pusey, A.M., M.D., Professor of Dermatology in the University of Illinois, etc. London: Sydney Appleton. 1907. 25s. net.

(*b*) "Diseases of the Larynx." By Harold Barwell, M.B., F.R.C.S. London: Henry Frowde and Hodder and Stoughton.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Post-Operative Results of Prostatectomy.—F. Cabot gives a series of 62 cases, with four deaths (*Postgraduate*, September, 1907), from his experience of the operation of prostatectomy. He advises: 1. Never remove a prostate if there is any question of the patient's fitness to resist the shock; do a preliminary drainage, suprapubic, and await developments. 2. Employ local anæsthesia for the preliminary cystotomy when possible. 3. Never use ether for prostatic enucleation. 4. Be sure the bladder is completely drained after the operation, and that the patient leaves his bed in a day or two for his meals. 5. Choice of method: perineal route in 20 per cent.; suprapubic at one sitting 40 per cent.; Lilienthal's interval operation, 40 per cent. 6. Perineal route suitable for simple uncomplicated prostatic hypertrophy (when small). 7. Suprapubic route in all severe, complicated cases, and in about one-half of these cases the two stage methods of Lilienthal should be employed. 8. Cystoscopy is of value, but prolonged efforts to use it should not be employed. G.

Congenital Stenosis of the Pylorus.—H. Sheffield (*Postgraduate*, August, 1907).—Stenosis of the pyloric end of the stomach may be complete or partial. In the first case death is only a matter of hours; in the second, the child may live, and, if suitably treated, recover. While complete atresia is very rare, and almost never diagnosed until a post-mortem examination reveals the condition, a partial stenosis is by no means uncommon. The true stenosis is invariably due to a congenital narrowing of the lumen of the pylorus, and is associated with more or less hypertrophy of the pyloric ring. False or spastic pyloric stenosis is the result of congenital faulty inervation of the stomach, or of acquired digestive and nervous disturbance. It is free from primary hypertrophy of the pyloric ring. Sooner or later secondary hypertrophy of the muscular and mucous coats of the stomach occurs in consequence of the increased force required by the stomach to expel its contents. The symptoms, as a rule, are definite. After a period of from one to three weeks' good health, the infant begins to vomit; this vomiting increases in severity; the amount of food brought back often appears greater than the child had swallowed, and is free from bile. There is pseudo-constipation, with scanty concentrated urine. The child appears to be nearly always hungry, but after a few mouthfuls of food is seized with colicky pains and refuses its bottle, only to grasp it again when some relief prevails. The abdomen is sunken in below, while the epigastrium is distended. In some cases the hypertrophied pylorus may be palpated as a distinct tumour. In the cases of false or spastic stenosis, the symptoms are much the same, but are not so marked. This form of disease may, and often does, yield to medical treatment, the true stenosis, on the other hand, being always fatal unless treated surgically. The author believes, in all cases of congenital pyloric stenosis, if after two weeks' faithful but unsuccessful trial of dietetic and medicinal treatment, an operation should be recommended in bottle-fed children presenting the usual symptoms of pyloric stenosis, plus pyloric tumour. In breast-fed infants presenting the usual symptoms of pyloric stenosis, even if there be no palpable pyloric tumour present, the choice between divulsion, pyloroplasty, and gastro-enterostomy depends upon the pathological condition of each individual case. G.

Primary Cancer of the Appendix.—Hartmann (*Bulletin de Chir.*, No. 8, 1907) reports two cases of carcinoma of the appendix, occurring in a series of 50 cases examined for carcinoma, and mentions 40 other cases of this disease which have been recorded during the past three years. It seems most probable that carcinoma is a far more common affection of the appendix than is generally supposed. The growth is usually very small, and readily escapes notice in the inflamed appendix unless most careful microscopic search is made. The cancerous growth in most cases involved an obliterated part of the appendix. In most of the cases the growth has been an adeno-carcinoma, and developed mainly between the ages of twenty and thirty years. The prognosis of the disease is uncertain, but cases are recorded in which no return of the disease had taken place four years after the removal of the cancerous appendix. G.

Important Change in the Blood and Urine in Appendicitis.—A. Pisani (*Postgraduate*, September, 1907) gives a number of cases of appendicitis in which a careful examination of the blood and urine had been carried out. From these he draws the following conclusions: The necessity for cleansing the intestinal canal by cathartics, thereby eliminating all causes which tend to produce any toxins due to putrefactive fermentation of the food-stuffs. (2) Abstaining from administering opiates or narcotics to relieve the pain, which mask the symptoms and cause constipation. (3) The obtaining of a thorough and accurate blood count, so as to arrive at a diagnosis whether pus formation exists, or especially obtaining a radionuclear count of the leucocytes so as to be able to form some opinion as to prognosis. (4) Frequent urine analyses, testing especially for indican, which would tend to show that putrefactive processes exist in the human economy, and that the disappearance of the same after operation proves progress of the patient. (5) The total daily output of urea should be determined daily in all inflammatory and suppurative processes, to see whether resolution is taking place, and the rapidity of the resolution, and when and how rapidly the repair is being effected. G.

A New Operation for Mobile Kidney.—Stanmore Bishop (*Brit. Med. Journ.*, October 5th, 1907) reaches the kidney through the anterior abdominal wall. The peritoneum is divided transversely over its lower pole, and the true capsule of the kidney is also split across just below the renal pelvis. The capsule is then stripped inwards and downwards from the kidney, still, however, remaining attached internally and posteriorly. The divided edges of the peritoneum are re-united. A long silk thread, armed at each end by a long straight needle, is then taken. One of these needles is inserted in an antero-posterior direction immediately below the lower edge of the renal pelvis, passing through the peritoneum, reflected capsules, and muscles of the back, and emerging through the skin behind. The second needle is in like manner passed at the inner border of the kidney 1 to 1½ cm. lower down. Three or four similar stitches are passed around and below the kidney in the same way. Each pair of threads forming a loop is then drawn up firmly and tied in a groove formed by the division of the skin between them, so becoming buried. The tying of the loops draws the incisions between the needles into a point, so that no suturing of the skin is required. The abdomen is then closed. The author has performed this operation in 10 cases. The first two relapsed, as a grip of the kidney capsule was not taken by the stitches. S.

Fracture of the Neck of the Femur: A New Treatment.—Gallie (*Canada Lancet*, September, 1907) says that the clinical efficiency of the method of treatment detailed below has been corroborated by observations made on eight cadavers. The procedure is as follows: The patient is anæsthetised and elevated on a pelvic rest, which does not interfere with the bandages as they are applied. The surgeon stands beside the injured hip. If the fracture is impacted, an assistant forcibly abducts the limb under moderate traction, breaking down the impaction and only stopping when an angle of 50 degrees from the normal has been reached. The surgeon maintains a downward pressure on the trochanter with the palm of the hand, and gently lifts it forward, and rotates the limb slightly inwards. No attempt is made to elicit crepitus. If the fracture be complete and unimpacted, the assistant first overcomes all shortening by strong traction, counter traction being provided by a towel against the perineum. He then abducts the limb in the same way. When the surgeon is satisfied with the results of the manipulations, the bony points are padded, a plaster spica is applied from the toes to the mammary line. The plaster is well moulded in by the side of the pelvis and trochanter, so that displacement may be rendered impossible. After some days an X-ray photograph should be taken through the plaster. The best time for the application of the treatment is immediately after the injury, unless lacerated tissues require preliminary treatment. At the end of four weeks the plaster case may be shortened to allow free movement of the knee, and may be completely removed in eight weeks. After this the best routine plan is to use a light short plaster spica, holding the limb in moderate abduction. At first the patient uses crutches, and then gradually resumes weight-bearing. This plan of treatment is recommended for all fractures of the neck of the femur occurring in the young and in adults up to 55 years of age. S.

The Treatment of Weak or Flat Foot.—Whitman (*Med. Record*, August 31st, 1907) says that the influence of modified shoes (raised on the inner side), attention to posture, and the cultivation of muscular strength may be quite sufficient to cure milder cases of the above disability, if the co-operation of an intelligent patient is assured. Exercises are most important. As the adductors of the foot have been weakened by inactivity, the patient is instructed to invert the foot voluntarily over and over again. The following exercise is most important: The patient stands erect, markedly toeing in, with the weight thrown on the outer borders of the feet. The body is then raised on tiptoe with the full extension of the limbs; then it is allowed to sink slowly back, the feet during the descent being gradually inverted, reaching finally the extreme limit when weight is borne. In most cases, however, the tendency towards deformity has advanced so far that it cannot be controlled by the patient, and a brace is usually an indispensable adjunct in treatment. Whitman's brace is made as follows: A plaster mould of the foot, slightly adducted, is first made. On the cast from this the brace is fitted. Its inner margin rises above the astragalo-navicular joint. The outer side covers the anterior two-thirds of the os calcis and the cuboid bones, enclosing this joint. The sole part of the brace extends from the bearing surface of the heel to the bearing surface of the first metatarsal bone. The front and outer two-thirds of the sole are not supported unless there is breaking down of the metatarsal arch. The author considers that a brace should not be an agent to supplant developmental treatment, but one that, by enforcing normal posture, makes such treatment effective. S.

Skin Grafting by a Modification of the Wolfe-Krause (Whole Thickness of the Skin) Method.—Young (*Glasgow Med. Journ.*, October, 1907) describes eleven cases demonstrating the excellent results obtained in his modification of the above method of skin grafting. The grafts are made expeditiously by cutting straight down to the aponeurotic covering of the muscles. The whole flap is removed and placed in warm saline. The fresh wound is forthwith closed completely by suture and dressed with aseptic care. The surface to be grafted is now uncovered. If it is a fresh operation wound, the only preliminary to the application of the graft or grafts is the thorough checking of hæmorrhage. If asepsis of the wounds is not practicable, as in burns, all necrotic tissue and exuberant granulation should be removed some days before, and the surface of the ulcer should be smooth and of a healthy rose-pink colour. Contrary to the teaching of Thiersch, it is unnecessary, and probably a disadvantage, to remove the superficial layers of a granulating surface. The flap of skin and fat is now placed on the palm of the hand, and the fat is readily and quickly removed by cutting it away with a scissors curved on the flat. If the surface to be covered is large, the flap is divided into a number of pieces. The wound, when the grafts have been applied, should be covered with oil-silk or gutta-percha tissue suitably perforated. This protection is not interfered with for several days. The moist saline dressing outside the protection should be changed daily. The author calls special attention to the case of a woman, æt. 70, in whom, although she was in a practically moribund condition, the grafts lived and grew peripherally. Microscopic section of the grafts (obtained post-mortem eight days later) strikingly demonstrated the greater activity in initial extension of the stratum lucidum as compared with the rest of the superficial layers of the skin. S.

The Production of a Filtering Cicatrix in Chronic Glaucoma.—Félix Lagrange (*The Ophthalmoscope*, September, 1907) has devised the following operation for producing a filtering cicatrix without producing an entanglement of the iris. Eserine is instilled half an hour before operation to facilitate the passage of the knife, and to keep the iris away from the wound. After cocaine and adrenalin have been well instilled, the sclera is punctured 1 m.m. from the limbus, and the counter puncture is made at a corresponding point. The sclera is divided in the irido-corneal angle. In finishing the incision, the cutting edge of the blade is directed backwards, so that the sclera is bevelled "like the mouthpiece of a flute," and a large conjunctival flap formed. Without injuring the conjunctival flap, a piece of the exterior lip of the incision is resected with very sharp, specially made curved scissors. The iridectomy is now performed in the ordinary way, and the conjunctival flap used to cover the wound. Lagrange has published 27 cases treated by this operation, which have been watched for periods exceeding six months. Of these, four were not followed, and three remained without result, because he failed to obtain a filtering cicatrix on account of excising too small a piece of the sclera. The remaining 20 cases were good results—the vision having been improved in twelve and maintained in eight. M.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.

At a quarterly meeting of the Council, held on Thursday last, Mr. Henry Morris, president, was elected to give evidence on behalf of the College before the Committee which has been appointed by the Home Secretary on the subject of the "London Ambulance Service." Mr. H. H. Clutton was elected a member of the Executive Committee of the "Imperial Cancer Research Fund," in place of Sir John Tweedy, retired, and Mr. Edmund Owen was re-elected a member of the same Committee. Mr. L. A. Dunn, surgeon to Guy's Hospital, was introduced, and, having made the required declaration, was admitted a member of the Court of Examiners.

The Secretary reported the death of Mr. Timothy Holmes, and the Council passed a vote of condolence to his widow, at the same time placing on record their appreciation of the services rendered by Mr. Holmes to the College in the conscientious discharge of the several duties which for many years had devolved upon him. The Council also expressed their deep regret at the death of Professor Charles Stewart, and their sincere sympathy with his widow and family in their bereavement. The Council further expressed their sense of the great advantages which the College had derived from Professor Stewart's rare knowledge of all branches of science represented in the Museum, and recorded their appreciation of the zeal and ability which he displayed in performing the duties of Conservator of the Museum during the past 23 years.

The following candidates were admitted Members of the College: R. Jamison, M.A., St. Bart.'s; R. J. P. McCulloch, Toronto and Lond. Hosp.; C. H. Montgomery, Toronto; D. G. Pearson, Cambridge and St. Bart.'s; and A. J. Turner, Durh. Univ. and London Hosp. The president reported that he attended the centenary celebrations of the Geological Society of London as the representative of the College, and had presented an address of congratulation on behalf of the Council. The report to be presented to the Fellows and Members at the annual meeting, which is to be held at the College on Thursday, November 21st, was considered and adopted.

Deaths under Anæsthesia.

A verdict of death by misadventure was returned on the 14th inst. by a coroner's jury in the case of a married woman, 29 years of age, who died at Guy's Hospital on October 3rd, whilst undergoing an operation (tying the inferior thyroid arteries) for exophthalmic goitre. Chloroform was administered by the house surgeon, and ten minutes after inhalation commenced the patient turned colour and died, directly after the surgeon, Mr. C. J. Symonds, had made his incision. The heart was somewhat dilated and fatty. Both the surgeon and the house surgeon admitted that the case was one of recognised anæsthetic danger. The Coroner of the City of London, Dr. Waldo, pointed out that, in spite of that fact, the chloroform was entrusted to the house surgeon, who had administered anæsthetics in 98 cases only, instead of to one of the eight anæsthetists attached to the hospital. The question raised was one of system. Whilst recognising the necessity of medical men being trained in the administration of anæsthetics, he maintained that all cases of known gravity should be entrusted only to anæsthetists of long experience. The jury found that the chloroform was administered with reasonable skill, considering the limited experience of the administrator. They appended a rider recommending that in future operative cases of a serious nature anæsthetics should be administered either by a staff administrator or under his immediate supervision. They also recommended that full statistical returns of all anæsthesia cases should be kept at Guy's Hospital.

Great Northern Central Hospital, London, N.

An attempt is being made at the hospital to utilise the exceptionally large amount of clinical material which is available for the purpose of teaching and study. A course of clinical lectures has been arranged, the second of which will be given on Friday, October 18th, by Mr. Arthur Edmunds on "Some Practical Points in the Diagnosis and Treatment of Appendicitis." In addition to this, the wards and out-patients' department are open to students and practitioners of medicine, and demonstrations are given at regular hours. The hospital contains 160 beds, a double set of operating theatres, and accessory rooms, and all the equipment of a first-grade modern hospital. The opening of two new electric railways with stations at Holloway Road and Highgate respectively has made the hospital one of the most accessible in London; and this fact, combined with the abundance of material for study, should make the hospital of much more than local importance.

A Medical Motorist.

At Ongar, on October 5th, Dr. Butler Harris was summoned for motoring at an excessive speed. The police evidence was to the effect that defendant drove his motor-car at 30 miles an hour. Defendant absolutely denied that he was going at 30 miles an hour, because his car was incapable of doing it. On the day in question he attended a patient at Coopersdale, and hearing that someone had been seriously injured at a farm fire at Stanford Rivers he hurried forward, but found that this was not so. He protested against medical men being pilloried in this manner. This was the fourth time within the last three years that he had been before the Justices for motor driving, and only on one occasion—when the case was dismissed—had there been any allegations of reckless or inconsiderate driving. If the police continued to pillory him in this way it would make the continuance of his country work almost an impossibility, because there was probably no day upon which he did not go at the rate of 23 or 24 miles an hour on some part of his journey. He objected to the method of timing adopted by the police. Drivers heard nothing of the matters until two or three days had elapsed, and were therefore unable to prepare a defence. The Chairman, Mr. Tyndale White, said there was nothing in the Act to exempt medical men, although, personally, he sympathised with them, and wouldn't mind them going 60 miles an hour—he would only be too pleased. The Bench much regretted having to fine defendant £3 and costs, 4s., but they had no alternative.

Supt. Laver said these motor traps were set in consequence of complaints, and the proceedings were taken by order of the Chief Constable.

City Medical Officer's Bereavements.

Mrs. Collingridge, the wife of Dr. Collingridge, of Penrith, was found in her room dead from prussic acid poisoning. Mrs. Collingridge had only been married three months, and lately had apeared strange in her manner. As she did not appear yesterday morning her bedroom door was burst open, and Mrs. Collingridge was found dead. A bottle that had contained prussic acid was by her side, death having taken place several hours earlier.

Dr. Collingridge, who is the son of the medical officer for the City of London, is at present in a fever hospital, and Mrs. Collingridge, senior, died suddenly at Morland only a fortnight ago. The lady who was found dead yesterday was a daughter of Professor Klein, of Twickenham, and had arranged to meet her husband on his discharge from hospital to-day, and travel south with him. When he went into the hospital, suffering from scarlet fever, she went to her home, but returned to Morland on Saturday. On Monday and Wednesday she visited her husband, and on Thursday evening she appeared to be in good spirits. At the inquest the jury found a verdict of "Suicide during temporary insanity."

Royal Academy of Medicine in Ireland.

At the annual stated meeting of the Royal Academy of Medicine, held on the 11th inst., the following officers and Councils were elected for the coming year:—President, J. Magee Finny; General Secretary, James Craig; Secretary for Foreign Correspondence, Sir J. W. Moore.

Medical Section.—President, The President, R.C.P. (Joseph M. Redmond); W. J. Dargan, H. C. Drury, T. P. C. Kirkpatrick, J. A. Matson, T. G. Moorhead, A. R. Parsons, G. Peacocke, F. C. Purser, W. J. Thompson, W. A. Winter.

Surgical Section.—President, The President, R.C.S. (Sir H. R. Swanzy); C. A. Ball, Alex. Blayney, Sir A. Chance, G. J. Johnston, R. C. B. Maunsell, Seton Pringle, J. B. Storey, E. H. Taylor, W. Taylor, W. I. de C. Wheeler.

Obstetrical Section.—President, E. H. Tweedy; J. S. Ashe, Paul Carton, Gibbon FitzGibbon, M. J. Gibson, H. Jellett, F. W. Kidd, R. D. Purefoy, J. Spencer Sheill, A. J. Smith, Sir W. J. Smyly.

Pathological Section.—President, A. R. Parsons; H. C. Earl, L. G. Gunn, W. G. Harvey, H. C. Mooney, T. G. Moorhead, J. F. O'Carroll, A. C. O'Sullivan, J. A. Scott, A. H. White, J. T. Wigham.

Section of Anatomy and Physiology.—President, A. F. Dixon, A. Fraser, H. M. Johnston, E. L'E. Ledwich, E. P. M'Loughlin, W. H. Thompson.

Section of State Medicine.—President, W. R. Dawson; A. E. Boyd, T. P. C. Kirkpatrick, F. C. Martley, J. A. Matson, G. S. R. Stritch, W. A. Winter.

Westminster Hospital.

Under the chairmanship of Mr. A. H. Tubby, M.S., F.R.C.S., a highly successful annual dinner of the Past and Present Students of the Westminster Hospital took place at the Trocadero Restaurant on Thursday, October 3rd. In proposing the toast of "The Westminster Hospital and Medical School," the chairman pointed out the satisfactory working of the arrangement made with King's College for the teaching of the preliminary subjects. In these days, when the diminution in the numbers of medical students in London compelled the larger hospitals to put forth every effort to attract men, it became increasingly difficult for the smaller schools to keep up their numbers.

The Dean, Mr. Paton, in his reply, urged upon all Westminster men the necessity for individual effort in support of the school. It was in the power of the old students, much more than in that of the staff, to secure new students. Dr. Allchin, in proposing the toast of "The Guests," said the presence amongst them of Professor Halliburton and Professor Thompson was eloquent of the happy relations now existing between Westminster and King's College. The health of the "Old Students" was proposed by Dr. Hebb, and acknowledged by Dr. Macnamara.

Meath Hospital, Dublin.

The opening meeting of the session at this hospital was held on Wednesday last, when Dr. James Craig delivered the inaugural address. The President of the Royal College of Physicians presided, and the meeting was addressed by, amongst others, the President of the Royal College of Surgeons, Dr. J. M. Finny, Sir John Moore, and the Provost of Trinity College. Dr. Craig, whose address we hope to publish in a later issue, dealt with "The Choice of a Medical Career and Medical Ethics."

The Treatment of Lunatics.

At the meeting of the Hampstead Board of Guardians on October 10th, a letter was read from the Commissioners in Lunacy saying that they had seen in "The Times" a report of the inquest on the body of a man who died in the observation ward of the Hampstead Workhouse after having been there 17 hours, seven of which were spent in a strait jacket, without being seen by a doctor. The Commissioners presumed that the guardians would hold an inquiry into the circumstances, and they would be glad to be informed of the decision at which the Guardians might arrive. A letter was also read from Mr. Walter Schröder, the deputy coroner, stating that at the inquest the jury added a rider to their verdict to the effect that they considered it very desirable that every patient should be seen by the medical officer upon admission, or as soon after as possible, and that in no case should a strait jacket be applied without the authority of the medical officer. Mr. Schröder added that he had also sent a copy of the rider to the Local Government Board. Mr. H. C. Russell, the master of the workhouse, said that after the inquest he instructed the lunatic attendants to notify the medical officer immediately of the admission of any patient to the observation ward. It was resolved to refer both communications to a committee of the whole board for consideration and report.

London County Council Scholarships.

The London County Council will be prepared to award, in January, 1908, not more than six scholarships to students in midwifery. Candidates must be between the ages of 24 and 40, and must be resident within the County of London. The value of each scholarship will be £25, and the course of training provided will extend over a period of six months. Forms of application may be obtained not later than Saturday, November 19th, from the Executive Officer, L.C.C. Education Offices, Victoria Embankment, W.C., from whom further information may also be obtained.

PASS LISTS.

University of Glasgow.

The following candidates have passed the second professional examination for the degrees of M.B. and Ch.B. in the subjects indicated (A., Anatomy; P., Physiology; M., Materia Medica and Therapeutics):—

Archibald Aitchison (M.); William Shanks Alexander, M.A. (A., P.); John Allan (A., P., M.); Andrew Clark Anderson (A.); James George Anderson (A. P.); William Anderson (A. P. M.); Edgar Barnes, M.A. (A.); Arthur Munby Bayne (A. P.); Emile Augustine Cameron Beard (P. M.); Douglas Morris Borland (M.); John Adam Gib Burton (A. P.); James Cairns (A., P., M.); John Allan Munro Cameron (A., P., M.); James Lang Cochrane (A., P., M.); David Rutherford Cramb (A.); Charles Duguid, M.A. (M.); Thomas Scoular Fleming (P. M.); George Fletcher, M.A. (A.); Edward George Glover (M.); Robert Dunlop Goldie (M.); Joseph Graham (M.); John Granger (M.); John Gray (P. M.); William Howat, M.A. (A., P., M.); William Howie (P.); James Walker Jones (A., P., M.); David Neilson Knox (M.); Alexander Leishman (A. P.); William M'Adam, M.A. (M.); William Charles Macartney (A.); Donald M'Dougall (M.); Donald M'Intyre (A.); Thomas Mackinlay (M.); Donald Mackinnon (M.); William Alexander Maclennan (P.); Campbell Macmillan (A., P., M.); John William M'Nee (M.); Thomas Marlin (M.); William Aubrey Layard Marriott (A.); Donald Meek (A. M.); Angus Millar (P.); Hyacinth Bernard Wenceslaus Morgan (M.); Findlay Murchie (A. P. M.); Frederick Lewis Napier (A.); William Nicol (A.); Clark Nicholson, M.A. (A., P.); John Robertson (A., P.); William Wilkie Scott (A.); William Alexander Sewell (M.); Alexander Hunter Sinclair (A.); James Stewart Somerville (A. M.); Richmond Steel (M.); Arthur Ford Stewart (M.); Robert Sweet (M.); Aidan Gordon Wemyss Thomson (M.); Charles Hermann Wagner (A., P., M.); William Samuel Waterhouse (M.); James Brown Whitfield (M.); Henry Joseph Windsor (A., P., M.); William Richard Wiseman, M.A., B.Sc. (A., M.); David Yellowlees (M.); Douglas Young (M.); John Young (M.). Women.—Christina Barrowman (A.); Florence Ann Gallagher (A.); Euphemia Adamson Hay (A., M.); Jeanie Douglas M'Whirter, M.A. (A., P.); Margaret Muir (A.); Ethelwyn Mary Walters (M.); Marion Aitken Wylie, M.A. (A., P.).

The following have passed the third professional examination for the degrees of M.B. and Ch.B. in the subjects indicated (P., Pathology; M., Medical Jurisprudence and Public Health):—

David Anderson (M.); Thomas Archibald (M.); William Hunter Stirling Armstrong (P.); John Atkinson (P.); Alexander Ballantyne, M.A. (M.); John Blakely (M.); James Nimmo Brown, M.A. (M.); William Barrie Brownlie (M.); John Cameron (M.); Matthew Ignatius Thornton Cassidy (M.); Donald Clark (P.); Donald James Clark (M.); Alexander Beck Cluckie (M.); James Cook (Coalburn) (P. M.); Walter Dawson (P.); Thomas Scott Forrest (M.); William Leonard Forsyth (P.); John Fotheringham, B.Sc. (P., M.); Robert Dunlop Black Frew (P., M.); William Ernest Gemmell (M.); Alexander Thomas Arthur Gourlay (M.); Edward O'Driscoll Graham (P.); Thomas Harkin (P.); John Mitchell Henderson (M.); John M'Lean Hendry (P.); James Hall Hislop (P., M.); William Alexander Hislop (P. M.); Walter Hermann Kiep (P., M.); James Towers Kirkland (P.); William Leitch (P., M.); Daniel Conway M'Ardle (P.); Frank Crombie Macaulay (M.); Robert M'Carlie (P.); Joseph Glaister M'Cutcheon (P.); Alexander Macphail Macdonald (M.); William M'Kendrick (M.); Murdo Duncan Mackenzie (M.); Francis William Mackichan (M.); William Campbell Mackie (M.); John James Mackintosh (P., M.); James M'Millan M'Millan (P., M.); Allan Macpherson (M.); Murdo M'Kenzie M'Rae (P.); Andrew Maguire (P., M.); Frank Needham Marsh (M.); William Aikman Muir (M.); Charles Sutherland M'Kay Murison (M.); Watson Noble (P., M.); Ralph Montgomery Fullarton Picken, B.Sc. (M.); Richard Rae (M.); Henry Nimmo Rankin (M.); Hugo Given Robertson (P., M.); Allan Semple (P., M.); James Brown Sim (M.); William Stevenson (M.); Hugh Cochrane Storrie (M.); David Taylor (M.); Walter Telfer (M.); Arthur Turnbull, M.A., B.Sc. (P., M.); Hugh White (M.); David M'Gruther Wilson (P.); John Alexander Wilson (P., M.); John Youngson Wood (M.); Hugh Young (M.). Women.—Margaret Baird Sproul Darroch (M.); Olive Robertson (M.); Winifred Margaret Ross (M.); Jeanie Hinshaw Stewart (M.).

The following passed with distinction in the subjects indicated:—

Second Examination—In Anatomy—William Howat, M.A.; Alexander Leishman. In Physiology—John Allan Munro Cameron; Jeanie Douglas M'Whirter, M.A. In Materia Medica and Therapeutics—Edward George Glover; John Granger; William M'Adam, M.A.; John William M'Nee; Hyacinth Bernard Wenceslaus Morgan.

Third Examination—In Pathology—Arthur Turnbull, M.A., B.Sc. In Medical Jurisprudence and Public Health—Matthew Ignatius Thornton Cassidy; Francis William Mackichan; Ralph Montgomery Fullarton Picken, B.Sc.

NOTICES TO CORRESPONDENTS, &c.

☛ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Scotsman.—No official figures are furnished, but it is said that the Royal College of Physicians of London and the Royal College of Surgeons of England receive yearly about £12,000 in examination fees between them; of this amount about £8,000 goes to the examiners.

M. T.—We believe Southwark is the only London borough that favours compulsory notification of tuberculosis. At a recent meeting of the Borough Council the matter was dealt with. They then decided to make it a compulsorily notifiable disease. The Progressives argued that the new order would result in many men having to give up their employment, especially in view of the new Workmen's Compensation Act.

Seaside.—Yes, even shrimps are preserved with boracic acid. A shell-fish dealer was summoned at Southport only the other day for selling potted shrimps containing an excess of boracic acid. For the prosecution, it was stated that the pot of shrimps contained 107.6 grains of boracic acid to the pound. It was stated that the Corporation intends to prosecute in all cases in which the amount of boracic acid as a preservative exceeds 35 grains to the pound. For the defence, it was stated that the defendant had purchased the shrimps from a wholesale potter, who, owing to the scarcity of shrimps at Southport, had bought them at Manchester and had potted them exactly as received. The Bench inflicted a fine of 20s. and costs.

Occupation.—The total number of cases of poisoning and of anthrax reported to the Home Office under the Factory and Workshops Act during August was 58, there being 48 cases of lead poisoning, 2 of mercurial poisoning and 8 of anthrax. In addition to the above, 17 cases of lead poisoning were reported among house painters and plumbers. During the eight months ended August, 1907, the total number of cases of poisoning and of anthrax was 376, as compared with 484 in 1906. The number of deaths during the same period was 28, as against 36 in 1906. In addition there were 104 cases of lead poisoning (including 26 deaths) among house painters and plumbers in the first eight months of 1907, as compared with 111 (including 26 deaths) in the first eight months of 1906.

Meetings of the Societies, Lectures, &c.

Wednesday, October 16th.

Royal Microscopical Society (20 Hanover Square, W.).—8 p.m.: Papers:—Mr. A. A. C. E. Merlin: (1) Note on a New Prismatic Microscope Ocular; (2) On Ghost Images seen in the Secondaries of Coseinodiscous Asteromphalus.—Mr. A. Letherby: Systematic Exposure with Transmitted Light in Photomicrography.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. B. Abrahams: The Post-Influenzal Heart.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Thursday, October 17th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. H. Evans: Cysts and Cystic Conditions of the Neck.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson), X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture:—Mr. J. Cantlie: Recent Discoveries in Tropical Medicine.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Eczema (its Varieties, Symptoms, and Causes).

Friday, October 18th.

Society for the Study of Disease in Children (11 Chandos Street, Cavendish square, W.).—5 p.m.: Cases will be shown by Mr. S. Stephenson, Dr. Chisholm, Mr. G. Pernet, Mr. L. Mummery, Dr. Langmead, and others. Paper:—Dr. E. C. Williams: On the Simulation of Some of the Symptoms of Primary Amaurotic Idiocy by a Cerebral Tumour.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. H. W. Dodd: Clinique. (Eye.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—3.45 p.m.: Demonstration:—Mr. C. Nourse: Larynx.

Appointments.

Carlyle, Oliver, L.R.C.P. and S. Edin., House Physician and Pathologist at the Infirmary, Sunderland.

Chapel, K., M.B., B.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Rothwell District of the county of Northampton.

Cunliffe, E. N., M.D.Vict., M.B., B.S.Lond., M.R.C.P.Lond., Honorary Consulting Physician to the Colne Cottage Hospital.

Cunningham, Richard G., M.B., Ch.B., Senior House Surgeon at the Infirmary, Sunderland.

Dodds, Thomas George Boswall, M.D., B.Ch.Edin., Medical Officer to the Starcross (Devon) Branch of the Rational Association Friendly Society.

Fitzgerald, C. C., L.R.C.P. and S. Edin., L.F.P.S.Glasg., Junior Assistant Medical Officer at the Hope Hospital Union Infirmary, Salford.

Granger, Henry, M.R.C.S., L.R.C.P., Resident Medical Officer at the Royal Victoria Hospital, Bournemouth.

McLean, Murdo, M.A., M.B., Ch.B.Edin., House Surgeon at the Infirmary, Sunderland.

Vacancies.

Brighton, Hove, and Preston Dispensary.—House Surgeon. Salary, £160 per annum, with furnished rooms, coals, gas, washing, and attendance. Applications to C. Somers Clarke, Hon. Secretary, 113 Queen's Road, Brighton.

North Riding Lunatic Asylum, Clifton, York.—Junior Assistant Medical Officer. Salary, £150 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Woodilee Asylum, Lenzie.—Medical Officer. Salary, £150 per annum, with board, lodging, etc. Applications to Dr. Marr, Medical Superintendent.

The Finsbury Borough Council.—Medical Officer of Health. Salary, £600 per annum. Applications to G. W. Preston, Town Clerk, The Town Hall, Rosebery Avenue, E.C.

City of Birmingham.—Assistant Medical Officer of Health. Salary, £250 per annum. Applications to the Chairman of the Health Committee, Council House, Birmingham.

Carlisle Non-Provident Dispensary.—Resident Medical Officer. Salary, £150 per annum, with apartments (not board). Applications to the Hon. Secretary, Mr. G. A. Lightfoot, 23, Castle Street, Carlisle.

Edinburgh District Asylum, Bangour Village.—Second Assistant Physician. Salary, £120 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent, Bangour Village, Uphall.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary, £160 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

Births.

Fawcett.—On Oct. 9th, at High Park, Roscrea, Ireland, the wife of Edward Fawcett, M.D., of a son.

Thompson.—On Oct. 5th, at Tutshill, Chepstow, the wife of Cecil C. B. Thompson, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

Hunton—Young.—On Oct. 9th, at the Parish Church, Great Stainton, Frederick Hunton, M.D., of Sedgefield, to Eleanor Mary, daughter of the late William Joseph Young, J.P., D.L., of Wolviston Hall, Stockton.

Moore—Ravenscroft.—On Oct. 9th, at the Parish Church, Ewell, Surrey, John William, youngest son of the late R. H. Moore, F.R.C.S., Dublin, to Violet Hastings, only daughter of the late Honble. W. H. Ravenscroft, C.M.G., of Ceylon.

Mulkern—Voules.—On Oct. 8th, at St. Mary's Church, Wootton, Bedfordshire, Hubert Cowell Mulkern, M.D., second son of Alfred Courtney Mulkern, to Florence Emily, only daughter of the late Laurence Francis Voules.

Robinson—Ward.—On Oct. 8th, at Swanage Church, Gerald C. F. Robinson, F.R.C.S., son of Gerald Robinson, Esq., to Helen Margaret, elder daughter of Lieut.-Colonel A. C. Ward, late R.E.

Verling-Brown—Hair.—On Oct. 9th, at St. Peter's Church, Belsize Park, N.W., Charles Richard Verling-Brown, M.D., Lond., of Sutton, Surrey, elder son of the late Charles Brown, of "Carnarvon," Bournemouth, to Jane, younger daughter of J. Hair, Esq., of Hampstead.

Deaths.

Dredge.—On Oct. 8th, at Melrose, Glastonbury, Captain J. A. Dredge, I.M.S., Staff Surgeon at Bangalore. (Accidentally killed out riding.)

Elliott.—On Oct. 6th, at Hull, George Frederick Elliott, M.D., F.R.C.P., England.

Heath.—On Oct. 4th, Edward Alfred Heath, M.D., of 34, Ebury Street, London, and Shoreham, Kent, aged 68.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, OCT. 23, 1907. No. 17

NOTES AND COMMENTS.

Defeat of Southend.

SOUTHEND is emerging ignominiously out of its contest with its medical officer of health. As the result of the attitude of loyalty to their colleague taken by medical men generally, the advertisements issued by the Southend Town Council only elicited four replies from applicants for the post, and not one of these was suitable. Considering that when Dr. Nash was originally appointed a few years ago there were forty-eight applications, most of them presumably from qualified men, it cannot be said that there is no cohesiveness in the profession when a question of principle is at issue. Whatever the unfortunate dispute has or has not done, it has at least shown that there is now a fairly well organised *esprit de corps* among medical men, and that this spirit is a factor to be taken into consideration by public bodies who try to play fast and loose with their medical officials. On that let us at least congratulate ourselves, for in the case of medicine it is as true as ever it was, that united we stand, divided we fall. We do not envy the Health Committee of Southend their position, for they themselves are aware of Dr. Nash's value and uprightness, and yet, acting under the orders of the Council, they have to find a successor to him in face of a practically unanimous boycott by the medical profession. At present matters stand thus. Finding no suitable man can be obtained for the post, the Health Committee were bound at the last meeting to recommend that Dr. Nash should be re-appointed for another year at the proper salary, namely, £600 a year, and of course this proposal was very distasteful to the Council, especially to those members who had come into conflict with Dr. Nash through their own sanitary shortcomings. Needless to say, the recommendation was opposed in every way, but it had perforce to be carried eventually, the only modification being that the period of re-appointment was shortened to nine months.

The Need for Inquiry.

Now this period, it seems to us, is quite long enough for the question to be thoroughly investigated by the Local Government Board. The health of Southend and the efficiency of the health administration of the whole country is bound up in its settlement. Mr. Burns, with his long experience of local authorities, and Dr. Macnamara, by his recent declarations, are both fully alive to the unsatisfactory and anomalous position in which health officers are placed by the insecurity of their tenure, and they must know that in the result hundreds of wrongs that need righting are untouched, because the very man who could tackle them is unable to act without risking the loss of his livelihood. The Southend case would make an admirable subject for a public inquiry by the Board, because it contains the elements which compose all difficulties of the kind, *plus* a medical officer of more than usual enterprise, and one who preferred his duty to soft words and ineffectiveness. If the Local Government Board leave things where they are, it is possible that the Council will be able to secure a medical officer at the end of the nine months, and the present fight will be in vain. On the other hand, if they hold an inquiry now, and, being satisfied as a result that Dr. Nash has been punished for doing his duty, intimate that they will not sanction any variation in the terms of his appointment, Southend will serve as a lesson to the rest of those sanitary authorities who set personal interests above public ones.

Cheltenham and its M.O.H

As a matter of fact, at the moment a similar fight is engaging the Council of Cheltenham. Dr. Garrett, the medical officer of health of that borough, is an energetic and well qualified man, who has raised the reputation of Cheltenham as a health resort to a high level. Unhappily, his care for the town has brought him into collision with the butchers, or certain butchers, whose slaughter-houses he has opposed, and with other parties whose private interests are not coincident with those of the public. Now, it is as inevitable that a conscientious medical officer of health should find himself in collision with private tradesmen as that a conscientious policeman should occasionally find himself under the painful necessity of injuring the feelings of Bill Sykes; human nature being what it is, there will always—this side of the millennium—be bad landlords, erring tradesmen, and incorrigible rogues. A medical officer who did not find any nuisances to abate would be as slack or incompetent as a policeman who found no thieves, but whereas society congratulates the policeman on his success, the medical officer (usually) gets kicks. The Cheltenham Town Council is being asked to reduce Dr. Garrett's salary by £100 a year as a reward for his energy and competence, and while we hope they will have nothing to say to so monstrous an injustice, we may, with some confidence, point to Southend as an example of what may happen if they give way. Happily, however, in the case of Cheltenham the Local Government Board have the last say in the matter.

Ici on parle Français.

THE line between legitimate and illegitimate advertising by medical men is so delicate a one that till the end of the chapter there is likely to be an infinity of disputes with regard to it. Whereas there are, unfortunately, members of the profession who stretch the elastic boundary to breaking-point, it cannot be denied that there is in some quarters a hyper-sensitiveness with regard to prominence attained by professional brothers. The important point to remember about medical rules is that they are laid down for the benefit of the public, and that medical etiquette is made for the man, and not man for etiquette. An amusing example of this hyper-sensitiveness has just occurred in Saxony, where the Medical Council of that State has decreed that it is derogatory to the dignity of medical men for one of them to indicate on his door-plate that he can speak English and French! Now, to a patient in a foreign town it may certainly be a deciding factor in selecting a doctor that he can speak the patient's native language, but who can say that such a reason is not perfectly legitimate? It must be convenient to foreign visitors to a town to know which doctors can be expected to understand them when they explain their symptoms, and which ones can merely, with strained sympathy, ejaculate "Ach" or "Ja." We can imagine that the General Medical Council would not smile if it became the fashion to adorn the dining-room windows in Harley Street with white letters announcing "Ici on parle Français," or "American Understood," but it would certainly be comforting for a man taken with abdominal pain in Naples to see "English spoken" on Signor Baccelli's plate.

German Legislation and its Consequences. THE recent German legislation prohibiting advertisements of quack medicines has caused some fluttering in the dovecotes of the gentlemen who live by that obnoxious trade. The *Advertising World* describes the legislation as grandmotherly, because it considers the German people the best educated in the world, and therefore able to "act with intelligence and discrimination." It seems to us that they have just given a signal proof of this ability by prohibiting advertisements which appeal solely to the ignorant and fleeceable members of the community. A correspondent of that journal, Mr. Robert Glasspole, of Coventry, writes to the editor an interesting and significant letter objecting to the comments made by him on this legislation. In the course of this letter Mr. Glasspole says: "I do not hesitate to express the opinion that sooner or later something will be done in this country, having the same object as that held in view by the German legislators when they made their law affecting patent medicines. Lest it should be thought that my argument is disinterested, I might say that I am myself an advertising man, and happen to know how, in some of the most notable instances, the copy issued (including the testimonials) is originated. As tending to show that I am not alone in my opinion, even amongst those connected with advertising, I should mention that in the advertisements of one of the most progressive advertising agencies in this country, there appeared not long ago the announcement that contracts for patent medicines would not be accepted." It is particularly striking that such strong and sane views should be held by a gentleman who is an advertising man himself, and we are thankful to know that there is at least one agency which will not lend itself to the duplicity and frauds of the quack medicine trade.

Retirement of Politzer. THE retirement of Professor Politzer, of Vienna, is an event of considerable interest, for he is acknowledged generally to be one of the pioneers of otology, and he has undoubtedly the highest international reputation of any practitioner of that branch of surgery. Professor Politzer owes much of his success to his ingenuity and to his manual dexterity. The latter he acquired in his early days as a painter, an art in which he earned no little skill and renown, and his originality of thought and method after devoting himself to otology are known all over the medical world. For thirty-six years he has been professor at Vienna, and it was only the other day that he brought out his enormous work on his speciality. The good wishes of many sufferers, and of all his medical colleagues, will follow him into his well-earned retirement.

LEADING ARTICLE.

THE ADMINISTRATION OF ANÆSTHETICS IN HOSPITALS.

THE points recently raised by the City of London Coroner, Dr. F. J. Waldo, have clearly enough an important bearing on the administration of anæthetics, as regards both the public and the medical profession. An inquest, as most of our readers are aware, was held on the body of a woman who died at Guy's Hospital some ten or fifteen minutes after the administration of chloroform was commenced by a house surgeon. The patient was suffering from exophthalmic goître, and the operator had just made the first incision, when the patient vomited slightly, or attempted to vomit, and then ceased breathing. It appears that the operation was performed at the day and hour usually fixed for such procedures, so that there was ample time to make the necessary preparations and to secure the attendance of one of the eight staff anæsthetists attached to the hospital. As regards this particular occasion, both the surgeon and the house surgeon admitted in evidence that they recognised that operation in cases of exopthalmic goître involved special anæsthetic difficulties. There is no need in these columns to dwell upon the peculiar risks involved therein in the position of the neck, the occasional pressure upon the trachea, the hypersensitive nervous mechanism concerned, and the frequently enlarged thymus. The point to be considered, however, is whether, with all these facts in view, any system can be countenanced which permits a house surgeon, whose experience is limited to some ninety or one hundred administrations, to give the anæsthetic, in spite of the fact that more experienced anæsthetists are available. At the inquest the house surgeon accepted all responsibility, but it may be doubted whether the public or the medical profession would approve such an assumption. Legally, we believe the responsibility rests with the operator, and in this particular case the surgeon said he was ready to accept part of the responsibility. The Coroner thereupon naturally pointed out that a man who was undertaking a difficult operation could not be expected at the same time to superintend the anæsthetic. The inquest thus centres upon the system in vogue at Guy's, and, for that matter, at many other hospitals throughout the kingdom. It is often a matter of convenience to the surgeon and to the hospital surgeons to have an anæsthetic administered on the spot by one of the resident staff. In many small institutions and country places it is absolutely the only course open to the operator. Nor in any big hospital would it be possible in a large number of surgical casualties to call in the services of a special anæsthetist. On the other hand, if there be any virtue at all in specialism in the administration of anæsthetics, not to mention staff appointments of that kind, it seems abundantly clear that special anæsthetists should attend all difficult operations where due notice can be given. The education of the student can be equally well, or probably far better, conducted by practical demonstration or by supervision than if he be left to his own unaided resources. It is of course necessary to instruct medical students in the administration of anæsthetics, which they are called to administer in after life under many varied circumstances, at times involving the assumption of the highest possible degree of direct personal responsibility. But while the necessity for a practical training must be freely admitted, it may, nevertheless, be a matter of question whether this or that given system of training is not open to improvement. In many ways the question of anæsthesia is of as much direct importance to the success of an operation as well as to the safety of the patient as the actual surgery which is involved. From this standpoint we venture to doubt whether sufficient importance is attached to the subject of practical anæsthetics in the medical curriculum. So far as the after career of the medical practitioner is concerned, we have little hesitation in saying that he would be better equipped for the battle of professional life by a sound education in anæsthetic administration than by the study of technical experimental physiology and other highly specialised branches of scientific work having a more or less indirect bearing on medical practice. So far as Guy's Hospital is concerned, we have no doubt that the authorities will take immediate steps to review the situation and to introduce any alterations in the present system that may appear necessary or desirable. An institution of that standing is so far above suspicion that no reasonable person would blame the authorities were any administrative defect shown to exist. At the same time, it must be borne in mind that all human organisations are fallible, and that with increasing knowledge and experience reforms are necessary from time to time if they are to keep abreast of the progress of knowledge and experience. In our opinion, the time has arrived when, in the interests of the community, an authoritative Government enquiry is demanded into the whole question of anæsthetics and their administration. We further think that such a Commission, to be of real value, should be constituted not solely of medical men, but of men eminent in science generally, of lawyers, and of others of acknowledged intellectual standing, in conjunction with a few medical men. Comparative statistics of all large hospitals should form an important feature of the evidence before such a Commission.

THE DEADLOCK AT THE ROYAL BRISTOL INFIRMARY.

The conflict of opinion that has arisen between the staff and the Board of Management of the Bristol Royal Infirmary shows little sign of settlement. In its essence the dispute becomes one of the right of a medical charity to say what outside duties may or may not be undertaken by its honorary medical staff. There is obviously something to be said on both sides of the question. If the Board finds its medical staff performing outside duties of such a nature as to interfere with the attention due, in the first instance, to the patients of the Royal Infirmary, it has clearly a right to expostulate and, if necessary, even to revise the terms of an appointment the duties of which are perfunctorily performed. We are glad to believe, however, that such a hypothetical case would be of the very rarest occurrence in the medical profession. Any physician or surgeon finding his energies unduly drawn upon by an auxiliary appointment would naturally resign, not less as a duty to himself than to his colleagues and to the medical profession outside the walls of the hospital. It would be useless to attempt to disguise the fact that plurality of appointments is open to serious abuses. Perhaps one of the greatest objections is that the pluralist, while holding a position to which he is personally unable to do justice, is, at the same time, excluding one of his own cloth from the higher things that undoubtedly attach to hospital life. So far as the Bristol Royal Infirmary is concerned, the medical staff have acted with commendable firmness and moderation. The new regulations passed by the governors—but not yet confirmed—provide that no member of the full staff shall hold any other professional public appointment except professorship or lectureship at any university, college or school; further, that only consultant or special practice shall be permitted. The medical staff accepted the latter clause, but have refused to acquiesce in the former, and have intimated that, in the event of its being retained, they will have reluctantly to send in their resignations. It would be a matter of profound regret were the outcome of these attempted changes to end in so disastrous a fashion. After all said and done, the services of the medical staff are purely honorary, and it is surely for themselves to regulate their own professional lives. While it is quite reasonable and, indeed, salutary that the governors of a charitable institution should be able to satisfy themselves at any moment that the work of the hospital is being conducted in the best interests of the public, we can by no means agree with the arbitrary and unconstitutional interference with the extramural rights of their honorary staffs. For the present the matter is in abeyance, but it will come up shortly for a final decision by the governors of the Bristol Royal Infirmary. It is impossible to think that the governors, without overwhelming evidence of the necessity of such a step, will estrange and eliminate their present staff by adopting rules that are condemned by the whole of the local medical practitioners, and thus reverse a policy under which the Bristol Royal Infirmary has for many generations faithfully and honourably discharged a great public responsibility.

Medical Sickness and Accident Society.

At the usual monthly meeting of the Executive Committee on the 11th inst., the investment of about £7,000, the surplus produced by the Society's operations through the summer, was arranged. The rate secured was 3¾ per cent., and this leaves a large margin over the rates assumed when the business of the society has been valued. The funds of the society now amount to over £215,000, of which £14,000 is treated as an investment reserve to cover any fall in the price of the Stock Exchange Securities held by the society, or any losses that may be incurred in any other manner.

CURRENT TOPICS.

The Alleged Dearth of Medical Men.

As a general statement, there seems little doubt that there has been for some years past an increasing difficulty in finding men to take junior resident posts in hospitals and other medical institutions. The rush of applicants, however, for adequately-paid appointments is just as great as ever, and the obvious deduction is that advantage has been taken of an overcrowded and disorganised profession to cut down salaries below a fair standard. A Manchester practitioner has recently written to a local newspaper, stating that not long ago he advertised for an assistant in his practice, and received no fewer than ninety-three replies, of which eighty came from suitable persons. We do not say what salary he offered, but we may infer that it was adequate to the purpose, judging from the result. The same correspondent appended an analysis of forty-four posts offered in a leading medical journal for medical men, the average remuneration being £90 per annum, with board and lodging. He remarks that, rather than spend £1,000 on educating a son of his to enable him to earn £90 yearly, it would be better to make him a bricklayer, as he might then perhaps live in comfort on such an income. The protest is vigorous, but is in itself hardly likely to contribute materially towards reform, unless, indeed, it suggests to hospitals which fail to secure residents that they should henceforth offer an adequate salary. The medical profession will never be able to secure fair remuneration until it is protected against the unfair competition of quacks and quackery; nor, it may be remarked incidentally, will the public safety and the national stamina be safeguarded until this elementary precaution be taken by the legislature.

Spotted Fever as a Test of Local Sanitation.

THE gospel of disease prevention could hardly find a finer text than that afforded by the recent report of the Local Government Board for Ireland upon "spotted fever" in Belfast. Dr. Clibborn, the inspector, attributes the outbreak to an infected coalheaver working on one of the ships from the Clyde. From the visit of that single patient sprang an epidemic of 233 cases, of which no fewer than 154 were fatal. This occurrence shows the enormous importance of an efficient system of port inspection. Although it would be a counsel of perfection to attempt to exclude all cases of minor infection, yet it is nevertheless possible to insist upon proper reports from the ship authorities, and a compulsory medical examination of all persons who are obviously ill. But the lessons of the Belfast outbreak by no means end with the necessity of port sanitation. The fact stands out in high relief that the disease establishes its foothold in filthy houses, and is propagated by actual human contact. Although there is much to be learnt with regard to the specific microbe of "spotted fever," we know that it cannot live long enough outside the human body to be propagated in dust, furniture, bedclothes, and so on. The moral is obvious. This terrible disease can flourish only in communities which permit the continuance of plague spots within their walls. As with some other communicable diseases, "spotted fever" could gain no grip in any district kept up to a reasonably high pitch of sanitary perfecton. Viewed from this standpoint, the extent and duration of an outbreak of the malady in question may be regarded as a kind of test imposed by Providence upon the sanitation of any given locality.

Some Medical Aspects of the Shrewsbury Railway Accident.

ONCE again the British public has been startled by a terrible accident to an express train. It seems likely that it will never be known why the train ran into a dangerous curve at such excessive speed, but the probable explanation appears to be that the brakes failed to act. The tragic fate that has overtaken so many of our fellow-countrymen suggests that it would be well to raise some obvious medical considerations at the present moment. The necessity of periodical inspection of the engine-men and guards has been often insisted upon in medical journals. One has only to reflect on the terrible consequences that may result from a momentary lapse of reason or attention on the part of an engine-man or a guard, to realise the need of full sanity of mind and body. Perhaps one of the points upon which the medical profession could insist with most advantage is that concerning the long hours of railway-men. It is absolutely impossible for an habitually over-worked man to keep his attention concentrated continuously upon his work. It is the momentary oblivion of the driver or the signalman that does the mischief. Parliament might do worse than appoint a medical commission of enquiry into the hours of railway-men, or, at any rate, a commission in which the profession of medicine would be strongly represented.

Army Reform and the Medical Profession

IN the scheme for the reform of the Territorial Army, which was foreshadowed by Mr. Haldane in his speech at North Berwick last week, a reference was made to the assistance which he hopes to get from the medical profession. So far as can be made out from Mr. Haldane's brief sketch, it is intended to reorganise a medical force for the Territorial Army on lines similar to those on which the Royal Army Medical Corps runs for the Regular Army. This Territorial Medical Service will be wanted, in time of war, not only to treat wounds but to secure sanitation and health preservation. The various medical units which are necessary will be raised, as far as possible, within the areas in which the divisions are formed. Outside these units the co-operation of experts in preventive medicine will be invited, whose advice will be asked in time of war, should troops be massed in their neighbourhood. Undue demands will not, however, be made on their time, and there will be nothing in any part of the scheme to interfere with the civil occupations of those taking part in it. It is, of course, impossible to criticise Mr. Haldane's scheme until we know something more of it in detail. At the same time, there is no doubt that it is a good intention to interest members of the medical profession throughout the country in national defence, so that they may prove of use in the event of war. Mr. Haldane may be assured of the active support of members of the profession in the carrying out of any sound scheme.

Milk Contamination.

It is not long since that our countrymen stood aghast at the horrors of the American tinned meat factories. It now appears that they may have their fill of that sort of thing without going across the Atlantic; indeed, by simply turning to the milk can at their own doors. A London milkman was recently charged on a warrant with selling unwholesome milk. The Westminster Medical Officer of Health deposed that the milk seized from prisoner had a number of black smuts floating on its surface: the fluid smelt offensively, and there was a large quantity of filthy material at the bottom of the can. This sediment was found to contain a large quantity of vegetable and other débris, consisting of hairs—some human and others belonging to small animals—pieces of human skin, and other most objectionable matter. The refuse apparently came from a dirty stable or the street, and it may be conjectured that some of it was due to dipping out the milk with a dirty can. The milkman cynically suggested it was due to the fog, but that defence did not save him from a sentence of six months' hard labour. This heavy punishment should act as a warning to the milk trade. The patience of the public must soon be exhausted, and fresh legislation will be demanded to stop the noisy carts of the milkmen, their adulterations, and their traffic in milk of tuberculous cows, all of which constitute offences of a nature that would not be tolerated for a moment in the case of other tradesmen.

Specific Cruelty in Divorce.

The legal interpretation of "cruelty" is somewhat elastic and fanciful, a fact that to some extent indicates the insufficiency of the existing law. The communication of venereal disease to a wife has happily long ago been included within the category of cruelty. Moreover, the advance of medical science has now made it possible to produce absolute evidence in the shape of bacteriological proof of the existence of both syphilis and gonorrhœa. From a recent judicial utterance it may be gathered that the mere fact of specific infection of the kind mentioned constitutes a sufficient ground for divorce, apart from any further question of legal cruelty. Mr. Justice Bucknill, however, in the course of the recent hearing of a painful case of the kind from Nottingham, made an important judicial utterance upon the subject. After commenting upon the present state of the law, he added that, in his opinion, it ought to be made a criminal offence for a man wilfully to communicate a specific disease to his wife. The Medical Press and Circular goes a good deal further than that, and maintains that it ought to be made a criminal offence for any man knowingly to communicate a venereal disease to a woman, or vice-versâ, on the absolutely clear and definite principle adopted by the legislature in the case of ordinary specific communicable diseases. Why punish a man for spreading small-pox but not the wanton dissemination of syphilis?

The Sheffield Infirmary Appointments.

We learn that the Sheffield Guardians propose to appoint as Medical Officer of the hospital a gentleman with greater experience, who will be able to take full control of the medical work. There will be two junior officers as before. They do not propose filling the position of visiting surgeon and visiting physician vacated by Dr. Wilkinson and Dr. Arthur Hall. But that will not prevent the Hospital Committee calling in outside aid whenever it is required for surgical operations. The new Medical Officer will be paid a salary of £300. It is understood that the Local Government Board representatives who recently visited the Workhouse Hospital fully approve of these changes.

PERSONAL.

H.M. the Queen has sent a donation of 600 guineas to the London Hospital.

Dr. Borger has been appointed personal physician to the King of Siam.

Mr. A. H. Lees has been appointed to a Research Studentship in Medical Entomology at Cambridge.

Mr. Rushton Parker has resigned his post of senior surgeon to the Liverpool Royal Infirmary, his term of office having expired.

Mr. Nathan Strauss, of New York, has offered a pasteurising plant to the cities of Dublin and Liverpool, in connection with their scheme for reducing infantile mortality.

Mr. Joseph Montagu Cotterill, M.B., C.M.Edin., F.R.C.S., was unanimously elected President of the Royal College of Surgeons, Edinburgh, on Wednesday last.

Mdme. Zola has presented to the Assistance Publique of Paris her house and grounds at Medan as a convalescent home for infants. Dr. Méry has been appointed physician to the establishment.

Dr. Koch, who has been examining the causes of sleeping sickness, left Mombasa for Germany on October 15th. His investigation camps in Uganda have been taken over by the colonial authorities.

Mr. Victor Thomas Ellwood, of Merchant Taylors' School, has been elected to the Medical Scholarship instituted at Pembroke College, Oxford University, by Dr. Theodore Williams.

Dr. T. Sangster Greig has been the recipient of a handsome testimonial from the staff of the West Ham Infirmary. Dr. Greig has been Acting Medical Superintendent of the Institution for some time, and has failed to be elected to the post permanently.

The friends and pupils of Dr. Hallopeau are subscribing for the presentation to him of a medal, executed by M. Chaplain. The list is open till November 10th, and all subscribers of twenty-five francs will receive a replica of the medal.

Dr. Edward W. Hope, Medical Officer of Health for Liverpool, and Professor of Public Health in the University of Liverpool, delivered an address on "Some present problems of public health administration" at the inaugural meeting of the York Medical Society last week.

Dr. Edgar Byass, of Cuckfield, who, for health reasons is leaving the district, has just been presented with a handsome parting gift of £417, together with a bound list of the subscribers. The Byass family have been associated with medical practice at Cuckfield for over 100 years.

A CLINICAL LECTURE

ON

URÆMIC MENINGITIS. (a)

By PROFESSOR R. LEPINE, M.D.,

Of the Lyons Faculty of Medicine.

Is there such a thing as uræmic meningitis? Pericarditis, as a complication of uræmia, is frequently observed, and whether it be a direct effect of the toxæmia or, as some hold, invariably the result of infection, the fact remains that the renal subject offers a favourable soil for its evolution. One thing is certain—*viz.*, that pericarditis becomes more frequent the nearer the approach of the uræmic state. Theoretically, therefore, I see no obvious reason why the meninges should not sometimes be affected like the pericardium.

I have not been able to find anything in medical literature bearing on the question, but three cases which have recently come under my observation suggest the possibility of such a relationship, and this I propose to discuss in the light of the information they afford.

The first patient was a labouring man, æt. 65, who had for some time previously been suffering from arterio-sclerosis, and was re-admitted in March with well-marked symptoms of kidney disease, and, in particular, general anasarca. Subjected forthwith to the dechloridation treatment, his state did not improve, and early in May he became delirious. He was still passing a fair quantity of urine (about four pints), but this was highly albuminous, and the elimination of methylene blue was greatly below normal. Little by little the uræmic condition became more marked, consequent upon the gradual failure of the heart. The pulse, which had been bounding (without any double murmur), became weak, and he died on May 31st, without either convulsions or coma.

Post mortem, the kidneys weighed 8½ ounces. The cortex was much atrophied, and the large, flaccid heart, more dilated than hypertrophied, weighed 20 ounces. The meninges over the convexity of the hemispheres were thickened, and were milky white except at one spot two or three inches square, which was bright red. The meninges were easily stripped from the subjacent grey matter, which was healthy, with the exception of a small patch of softening in the temporal convolution. The central parts of the brain were quite healthy.

No trace of tubercle was discovered in any of the organs or tissues, or cicatrices suggestive of healed tuberculosis.

The patient was reported to have been of sober habits, so that the thickening of the meninges could not have been due to alcohol. Its existence might be secondary to the renal condition, for during his two months' sojourn in hospital no other cause had intervened. To this acute process and the toxæmia the delirium was no doubt due, for the patch of softening did not appear to have played any part in its production.

Case 2 was that of a woman with kidney disease who developed delirium and sundry meningeal symptoms, and in whom, post mortem, the meninges were found to be of a bright red colour. She was æt. 45, and was brought to the hospital by neighbours, who knew very little about her history. She was very thin, had a vacant look, and could not be got to speak. She appeared, however, to understand to some extent what was said to her. There was no stiffness, and Kernig's sign was absent. The reflexes were exaggerated. Pulse 116, some rhonchi in both lungs. The urine, withdrawn by catheter, was of normal colour and albuminous. Lumbar puncture gave issue to a clear fluid. An enema brought away a large motion, without any improvement in her state.

The next day the heart beat was 128, with a tendency to gallop. The urine, mostly passed involuntarily, was darker and contained 17 per cent. of urea and the merest trace of albumen. There was some difficulty in swallowing, the face was turned to the right, the pupils were sometimes contracted, or at other times normal, the left being the larger. Respiration was noisy, but regular; the abdomen was soft. Examination of the urine on the 16th showed a marked diminution of phosphoric acid in proportion to the urea. A second lumbar puncture gave issue to fluid under moderate pressure (whereas on the previous occasion the pressure appeared to be high). Nothing particular was found therein. Post mortem, the atrophied kidneys weighed 3¾ ounces, while the heart weighed 12½ ounces. There was some cicatricial tissue in the apex of one lung that was probably of tuberculous origin. The cerebral meninges were much injected over the convexity, and several convolutions presented a bright red colouration. The cerebral ventricles were not dilated. No trace of exudation.

Case 3 was that of a young woman, æt. 30, admitted on May 12th. She was restless and delirious and had visual hallucinations. The rectal temperature was 104° F. Dr. Rome, who had been attending her, gave us the following particulars:—Her father, a chronic inebriate, died of ethylism at the age of sixty. She had lost a sister of meningitis at twenty-two. No tuberculosis in the family. She was spare, but healthy, was of sober habits, and lived a regular life. She had lost her mother five months before, and since that time she had become irritable, and for two months had suffered from headache. The actual attack had set in eight days before admission, with shivering that obliged her to keep to her bed. She remained in bed the following day on account of a "stitch" in the side. The temperature was high and the dyspnœa very pronounced. Dr. Rome was called in on the 11th, when respiration was rapid, there was slight dulness at the right base, with tubal breathing and crepitant rales. Pulse 130. Consciousness dulled. Violent delirium all night, and next day she was brought to the hospital.

At this stage the breath signs were barely audible at the right base, and the two symptoms that attracted our attention were the delirium and the retraction of the abdomen. No stiffness, no Kernig's sign, no exaggeration of the reflexes. Pulse 130.

On the 13th she was calm but unconscious. Some stiffness of the neck was noted and Kernig's sign was well marked. Lumbar puncture gave exit to a perfectly clear fluid, under a certain degree of pressure, containing a few lymphocytes and an occasional polynuclear cell. The physical signs at the right base had disappeared. The abdomen was still concave. Temperature barely 99.5° F. It fell the next day to 98° F., with a slow pulse. The patient vomited for the first time, and became comatose. Death took place on the 15th. Post mortem, the kidneys were found to be the seat of chronic nephritis and weighed 7¼ ounces. The heart weighed 11½ ounces. There was general congestion of the viscera. At the apex of one lung a few white spots were seen, which, however, did not look like grey tubercles. There was no trace of past tuberculous mischief.

(a) Delivered at the Hotel Dieu at Lyons.

The meninges were intensely red, with marked congestion of the cortex. Nothing was found at the base of the brain.

Careful examination of the apices of the lungs revealed nothing pointing to tuberculosis. The kidneys presented the characteristic lesions of vascular origin. A certain proportion of the arteries presented somewhat advanced lesions of arteritis and periarteritis. The case, then, was one of Bright's disease, with what appeared to be inflammatory redness of the meninges, limited to the convexity, without exudation or tuberculous granulations.

It is to be noted that this patient, on admission, presented a herpetic eruption on the lip. I have already pointed out that the broncho-pneumonic lesions did not present the histological appearances of the tuberculous process, and Ehrlich's diazo-reaction, which is always positive in tuberculosis, proved negative here.

The existence in the second case of old-standing lesions pointing to past tuberculous disease of the apex may suggest a tuberculous origin of the meningeal congestion, but these lesions gave one the impression of being quite "dead," and the low temperature militated against any such hypothesis. Lastly, a close examination of the meninges failed to reveal the slightest trace of granulations.

I do not, of course, pretend that tuberculous infection is necessarily associated with the presence of granulations. The nature of a given lesion is to a certain extent independent of the anatomical characters which it displays. This is an unquestionable fact upon which, in respect of tuberculosis as it happens, Prof. Poncet has very properly insisted of late. But for the above reasons it appears to me highly improbable that there was anything tuberculous in either of the two female patients just referred to. I may add that the rapid course of the malady, the freedom from disease of the base of the brain, and the absence of any meningeal reaction in the cerebro-spinal fluid, are points to be borne in mind.

To sum up, the first patient presented marked thickening of the meninges over the convexity, apparently due to the uræmia. In the two others the symptoms pointed to meningitis, and recent lesions were discovered. Unfortunately, owing to circumstances beyond our control, no histological examination of the meninges was made, so that we are not in a position to speak authoritatively as to the exact nature of the intense congestion found on the convex surface of the meninges and on certain areas of the cortex.

In spite of very careful examination of the cerebro-spinal fluid in the two cases, we were unable to obtain unquestionable evidence of meningeal inflammation, either because there was not free communication between the perivascular sheaths and the main cavity of the arachnoid—in which event the absence of a "cup" in the fluid does not prove the absence of a reaction in the sheaths, or because *acute* uræmia does not determine any reaction.

It should be noted that pericarditis is but rarely met with in acute uræmia. It is possible that the uræmic poisons, which are of endogenous origin, are less irritating to the tissues than exogenous poisons.

As a matter of fact, the nervous lesions hitherto mentioned by writers in connection with acute uræmia do not appear to have been manifestly inflammatory. Dr. Castaigne says: "Most frequently we find generalised or circumscribed œdema, sometimes congestion of the brain and meninges, with sub-arachnoid ecchymoses, which appear to be rather the effect than the cause of the uræmic accidents."

I do not know whether genuine inflammatory lesions have been found to be the basis of the auricular troubles in renal patients. As to the retina, I am aware that in renal subjects it is often the seat of exudation, and a special renal variety of retinitis has been described, but we do not find white patches in the early stages of uræmia.

In the absence of further information, therefore, I hold that inflammatory lesions are only produced in *chronic* uræmia. The meningo-eclamptic symptoms are acute disturbances, so that we must not be surprised to find that they are not dependent on frankly inflammatory lesions.

We must, indeed, not bind ourselves to the data afforded by pathological anatomy, and, to speak frankly, the symptoms are much more dependent on the distribution than on the nature of the morbid process. This is why we must learn to think physiologically, and not anatomically, as we are so often tempted to do. I do not pretend that the nature and intensity of the lesion are devoid of importance, for it is clear that the destruction of an organ must abolish its function, but so long as a lesion is not too advanced, and is, *à la rigueur*, curable, we must pay special attention to the functional disturbance, for that, after all, constitutes the disease.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by H. Oliphant Nicholson, M.D., F.R.C.P.E., Assistant Physician to the Royal Maternity Hospital, late Obstetric Physician to the New Town Dispensary, Edinburgh. Subject: "The Prevention of Fever in the Puerperium."*

ORIGINAL PAPERS.

SOME MEDICAL ASPECTS OF SPINAL CURVATURES.

By GEORGE W. F. MACNAUGHTON, M.D., M.R.C.P., F.R.C.S.E., etc.,

Physician, Kensington General Hospital.

When briefly considering these conditions, one may affirm that kyphosis, to a greater or less degree, is present as a natural state in the two extremes of life—in the infant, before the spinal muscles acquire power to assume and maintain the upright position; and in the aged, where the anterior margins of the intervertebral discs, becoming atrophied and inelastic, permit the natural tendency of the flexor muscles to prevail over the extensors. At other times, excluding rickets and Pott's disease, this antero-posterior curvature takes place in the cervical and upper dorsal segments in osteo-arthritis, in many cases of cardiac disease, especially where pain is a feature, in lung fibrosis, and chronic bronchitis, and more decidedly when accompanied by asthma.

Lordosis of a moderate degree is more frequently met with than kyphosis, but presents less medical interest. In persons with a pronounced lumbar forward curve, the head is generally large, the figure rounded and of medium height, with an abdomen disproportionately prominent to its circumferential measurement, while the hips are broad. The disabilities attendant thereupon are backache after walking a comparatively short distance, and in swimming on the breast the lower half of the body, being deep in the water as compared with the position of the thorax, progression is hindered. Further, the legs, by being upon a still lower plane, lack force in the kick and in their return to position, and thereby lose a considerable power of propulsion.

Scoliotic changes occurring in early life and the consequent deformities present a surgical rather than a medical aspect. The converse, however, obtains in those cases attributable to occupation, postures, and debility, and which have their advent between the ages of twenty and thirty years, or even later. In these the amount of curvature apparent upon examination is no real index to the severity of the patient's distress. Just as the incidence of a rapid, though moderate, flattening of the arch of the foot in the adult is followed by numbness, heaviness, and pain in the leg upon reasonable exertion, so does slight lateral curvature present a number of indefinite and desquatous symptoms, or these occipital and vertex headaches —visceral crises, more frequently intestinal than gastric, localised and diffused neuralgias, along with temporary trophic alterations, such as swelling of the hands, form a series indicative of spinal irritation, and frequently classed as hysterical or neurasthenic. When one considers the continual effort required of the central nervous system in maintaining the tone and relative positions of muscles, and the inherent strain upon these, which, in the presence of even a slight scoliosis, sustain, at a disadvantage, the erect position of the body, then it is justifiable to conclude that many cases of neurasthenia are the consequence of lateral curvature. Moreover, a number of the cephalalgias, particularly those which arise from attempts at reading, are due to that irritability of the sensorium which accompanies curvature, and not to defects in the visual organ.

During empyema, and occasionally phthisis, scoliosis occurs as an accommodative process. There are other physical signs of medical import, however, and, of these, changes in the apices of the lungs are perhaps the most deserving of attention; thus, to whichever side the curve in the dorsal region be inclined, the scapula of that side projects backwards, and the entire shoulder passes forwards and upwards, while anteriorly, the supra and infra-clavicular areas become prominent. On the other side of the thorax the changes in configuration are exactly the opposite, and the parts above and below the clavicle become flattened and depressed. Besides these abnormalities to be observed on inspection, the breath sounds on auscultation are altered, so that in the retracted regions the breathing is harsh, vesicular, or broncho-vesicular. The percussion note is impaired; and, notwithstanding that the fremitus is but little modified, the *ensemble* is like to early consolidation of the lung, and may be readily mistaken for it.

Although not attributable in any wise to the curvature which goes with marked right or left handedness, it should be noted that many persons of middle age, who are occupied in the finer manipulative movements, such as art and penmanship, show the walls of the arteries in the arm most employed to be thickened, and the veins more prominent than those of the opposite limb. This fact should be remembered when estimating the blood pressure of the individual.

POST-OPERATIVE INTESTINAL OBSTRUCTION.

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Post-operative intestinal obstruction is a condition which is not very commonly met with. It occurs on an average after about 1 per cent. of abdominal operations, and is said to be more frequent after vaginal hysterectomy than after other operations. I lost one case of vaginal hysterectomy from this cause four years ago; since then I have not encountered it again until this year, when the following two examples of the condition occurred in my practice.

Case I.—Isabella McD., æt. 34, was admitted to hospital on March 30th, 1907. She had been married eleven years, had borne two children, the younger eight years ago, and had had no miscarriages. Her menstruation was regular—of the four-weekly type, lasting about three days, and not excessive. She had noticed an abdominal tumour nine years before admission, which had grown gradually larger. About five years ago she had an attack of pain over the tumour, which recurred at first about every five months, and then with rapidly decreasing intervals, until the attack coincided with each menstrual period. The pain lasted, as a rule, two or three days. She was sent into hospital by Dr. Kennedy for an attack of more severity than usual, from which she had suffered for a week before admission.

On examination, she had all the signs of a large myoma, extending up to the costal margin, with a localised dry peritonitis. Her temperature on admission was 100.4° F., and her pulse 120. After four weeks' rest in bed and expectant treatment, her temperature was normal in the morning, but still rose to 99.5 or thereabouts in the evening. Her pulse had, however, come down to 86, and I thought it right to remove the tumour.

Accordingly, on May 1st, I performed a supra-vaginal hysterectomy. I found very extensive adhesions to the omentum, and as there was a good deal of hæmorrhage from its surface after these had been separated, I tied off and removed the major part of that organ. The tumour was adherent, by its posterior aspect, to the root of the mesentery, but was separated with less trouble than might have been anticipated. The abdominal cavity was well flushed with normal saline, and left full of the fluid when the incision (a ten-inch one) was closed in three layers.

The patient's temperature that evening was 99.5, and her pulse 120. She had a morphine hypodermic to quiet her through the night. Vomiting continued during the next day, and she was given a powder containing bismuth and sodium bicarbonate without effect. I ordered her a soap-and-water enema that evening, which acted well but did not check the vomiting. On the third day after operation she was still vomiting at intervals, though her pulse had come down to 100, and her temperature to normal. Next day her pulse went up again to 110. She was given a turpentine enema which moved her slightly, but she still continued to vomit. On the fifth day after operation distension of the abdomen began to make its appearance, and as her pulse had risen to 128, and the vomit was becoming rather fæcal in appearance, I re-opened her abdomen under chloroform and ether. Distended and injected bowel at once presented itself, and, on following this up, the obstruction was seen to be caused by a recent adhesion of the gut to the omental stump, causing a kink. The intestine distal to this was quite collapsed. I freed the adhesions, and buried the omental stump in the peritoneal flaps of the abdominal wound. There was a large quantity of dark and rather foul-smelling serum in the abdominal cavity, which I washed out with plenty of saline before closing the abdominal wound in layers.

The operation was done at five in the evening, and gas could be seen passing into the collapsed portion of the gut before the wound was closed, yet fæcal vomiting continued till eight the next morning. Shortly after flatus was passed, and vomiting ceased. The bowels moved of themselves about five in the evening, twenty-four hours after operation. One or two stitch abscesses developed, otherwise convalescence, though slow, was uneventful.

My second case Sarah P., æt. 38, was also married, but had had no children and no miscarriages. She could fix no date for the time when she first noticed her tumour. The symptoms complained of were pain in both sides of the abdomen for two or three years, frequent and painful micturition, and constipation which had lasted for three weeks. For these she was sent into hospital by Dr. Hunter, of Dunmurry, who assisted me at the operation. Menstruation was four-weekly in type, lasted five days, and was profuse. She had all the signs of a large fibromyoma of the uterus, occupying practically the whole abdomen.

Her temperature rose to 99.8 on the evening of admission, but dropped to normal for the three days following, and her bowels were well moved by white mixture. I operated on August 8th—four days after admission—and removed a large myomatous uterus with a good deal of difficulty, as it was adherent over almost its whole surface to omentum and intestines. To get at the posterior adhesions I had to bisect the tumour, and even with this help the operation took two hours. The patient's condition afterwards was very bad, but by dint of repeated saline and brandy enemata and injections of adrenalin she pulled round, and went home to Dunmurry three weeks and a half after operation. Although the wound healed by first intention, her temperature rose at intervals to between 100° and 101° from the seventh day after operation to the eighteenth day, which is of interest in the light of the sequel.

She left hospital on August 30th, apparently well, though, of course, weak, and shortly after Dr. Hunter tells me that the lower end of the scar gave way and commenced to discharge thin pus. On September 23rd, almost seven weeks after operation, Dr. Hunter was summoned to see her, and found her vomiting incessantly, and with such an alarmingly bad pulse that he did not expect her to live through the night. He gave her morphia hypodermically, and, as she was a little better next morning, asked me to see her with him. I found her still vomiting, with a pulse of 140 and some distension, and, as the surroundings were not favourable for operation, recommended her removal to hospital as her only chance, which she willingly consented to.

I re-opened the abdominal wound that afternoon, after curetting the suppurating sinus which still persisted in its lower end, and found a very interesting state of affairs. Distended bowel at once presented itself, which was studded with recent tubercles. An adhesion was present between a caseous focus in the omentum and the small intestine, causing a kink. This was freed, and the caseating area removed. Several thin stringy bands running in various directions, and binding down intestine beneath them, were cut away; and, lastly, three or four coils of gut, which had become adherent to one another, and had caused considerable narrowing of the lumen of one of them, were freed from each other. A considerable amount of ascitic fluid was present. Convalescence was delayed by the skin failing to unite at the seat of the sinus, but otherwise the case went on well; the patient's pulse came down, her general condition rapidly became good, and the bowel functions were re-established the next day, and have given no trouble since. What her prospects are in the future, with an undoubted tuberculous peritonitis, is, of course, very doubtful. It will be interesting to see whether laparotomy in this case has the beneficial effect which it certainly does produce at times in this type of disease.

These cases are worth recording, as post-operative ileus is a condition which, after being for many years the bugbear of the pioneers in abdominal surgery, now receives little attention either in text-books or in journals. There is no doubt that modern aseptic technique, and better judgment in choosing the time for operations, have done much to minimise the risks; still, abdominal operations of all kinds are now so frequent that it is rather a matter of surprise that more accidents of the kind are not reported.

I would like to emphasise the insidious character of the onset of symptoms in my first case. The main, in fact, the only symptom at first was vomiting. This was continuous with the usual post-anæsthetic vomiting, which may last for twenty-four hours or even longer, especially where the operation has been prolonged and morphia has been given afterwards. The danger-signal was the continuance of the vomiting after the second day. Two motions had been procured by the administration of enemata, so that symptom was negative. The points which, to my mind, established the diagnosis were distension, most marked in the lower half of the abdomen, and the rising pulse-rate, and when these appeared I resolved to operate at once.

In the case which I referred to at the beginning of this paper, and which I lost, the symptoms were still more equivocal; recurrent attacks of vomiting were succeeded by intervals during which the bowels acted and everything seemed to be right, until when the symptoms of obstruction became declared and permanent the patient was too far gone to be saved. The obstruction in that case was a kink due to an adhesion to the wound in the vagina, and had evidently been relieved from time to time by the bowel becoming straightened out.

My last case is an exceedingly interesting one. This patient had absolutely no history of any trouble whatever, until the pains due to inflammatory changes in the tumour first appeared. At the operation there was no sign of tubercle in the peritoneum, and yet a caseous focus must have been broken down in the manipulations necessary to separate the adhesions, with the result that the infection was spread over the serous lining, and an acute tuberculous process set on foot. Such cases add another risk to abdominal surgery, but one which, I hope, the operator will not often be called on to encounter.

It is of interest to note that the abdomen in each of these cases was filled with saline before being closed, which is supposed to be a preventive against the formation of adhesions. It is more than a coincidence that each case had suffered from active adhesive peritonitis before and almost up to the date of operation; but, on the other hand, in how many similar cases does one operate without any untoward result? The "abdominal facies" which one expects in acute obstruction was conspicuously absent, both patients being rather flushed and feverish-looking. I have met with this complication on the three occasions which I have narrated, in a total of upwards of 200 abdominal sections. I hope that these cases may be of interest, and possibly of some help, to other surgeons in dealing with a condition which is, in my experience, a rather insidious, but a very real danger after operation, although, if the diagnosis be made early and the proper treatment—viz., opening the abdomen—carried out before it is too late, the results, even in the most debilitated patients, are surprisingly good.

HÆMORRHAGIC RASHES. (a)

BY GEORGE PERNET.

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Hæmorrhagic lesions of the skin, using the term hæmorrhagic in a wide sense, are usually spoken of as petechiæ, ecchymoses and vibices. In a general way petechiæ apply to small punctate spots and ecchymoses to larger ones. They are bilateral in distribution, multiple, more or less circular, but may be irregular; of a bright red tint in the early stages, varying in shade with time, much as the play of colours so grossly exhibited by a subsiding black eye. Ecchymoses may become confluent and give rise to large livid patches and areas. Again, petechiæ may pick out the pilo-sebaceous apparatus. Hæmorrhagic spots are sometimes raised, especially in erythema multiforme conditions. In vesicular and bullous eruptions, when the onslaught is severe, the contents of the vesicles and bullæ may be hæmorrhagic. A very fine hæmorrhagic stippling is also observed as a complication in long-standing eczema and psoriasis of the lower limbs, especially when varicose veins are present. With regard to vibices, they occur as streaks. In addition to the cutaneous hæmorrhages proper, subcutaneous effusions of blood may also be present.

The distinctive feature of these lesions is that their colour does not disappear on pressure, owing to extravasated blood or blood-colouring matter, thus differing from a simple inflammatory process. The first thing to do, therefore, in such cases is to pass the finger firmly over the spots, bearing in mind that in some patients they may be very tender.

The parts usually affected are the lower limbs. Next in order of frequency are the forearms and arms, and more rarely the trunk and face.

It is usual to refer to hæmorrhagic cutaneous manifestations as purpura, but I need scarcely insist on the fact that this is merely designating a symptom. The point of course is to form an opinion as to the cause, in order that treatment may be as rational as possible. I am well aware that these remarks are at this time of day commonplaces, and I would not allude to the matter were it not that diseases of the skin are sometimes apparently dealt with as if they were something apart.

In the class of case I am considering, the purpuric symptom is one that always indicates a marked, not to say serious, derangement of the organism, and it is important to be on one's guard as to possible complications, such as internal hæmorrhages. On the other hand, the skin trouble may accompany or follow visceral or orificial bleeding, or be premonitory of some general infection.

The so-called primary purpuras are really signs of intoxications and infections arising from various causes, the individual state of the tissues and of the blood playing their part of course. In approaching a case of cutaneous hæmorrhage, therefore, the importtance of taking it on its merits and of not being misled by a label is obvious. It should be dealt with on general routine lines, with special insistence on occupation, habits, food and drink, a hæmophilic history, and so forth, and bearing in mind the specific fevers. The mouth and throat should always be carefully examined, and in the case of children especially, as I shall show further on, the lungs should not be overlooked. The urine must never be neglected, as it may reveal the presence of albumin, sugar, indican, etc., or indicate renal inadequacy.

The most common condition observed is erythema purpuricum, coming into the category of erythema multiforme. The patient is often a young woman whose occupation necessitates a good deal of standing. The rash is mainly confined to the legs and thighs, where numerous spots are found which do not disappear on pressure. The older ones, for the lesions come out in crops, are level with the skin, but recent ones will be found to be elevated when more carefully examined and the finger lightly passed over them. There is frequently a history of previous attacks, recurrent at certain times of the year, a fact readily ascertained in some instances by direct examination on account of the pigmented appearances left behind. The following cases succinctly stated may be adduced as showing the diversity of causes. A domestic servant, aged 23, in whom the purpuric erythema lesions had been going on for six months, and which started after "catarrh of the liver," so she stated, a good deal of blood being passed at that time per rectum. In another woman, aged 32, the petechial and ecchymotic rash one day old came out on the legs one day after eating some crab. She had had diarrhœa for three weeks. In the case of a man, aged 42, a musician playing at times in an orchestra, the rash appeared four weeks or so after an attack of influenza. Fresh lesions came out whenever he had to sit up late. No other cause could be definitely made out. The upright or sitting posture appears to be the determining cause in some instances.

A vegetarian diet appeared to be an important factor in a girl, aged 15, who had a natural distaste for meat, and could not be persuaded to eat any. As showing the importance of examining the throat, this was well brought out in a case which commenced with reddening of the palms, and was of three days' duration. The purpuric erythema attacked the legs mainly, but was also present on the back of the hands, elbows and arms, accompanied by swelling of the knees and ankles. On looking at the throat evidence of acute tonsillitis was discovered. In another case the only apparent cause was the bad condition of the buccal cavity and the neglected condition of the teeth, with pyorrhœa alveolaris. Old syphilis and diabetes insipidus were found to exist in a man, aged 28, who had suffered from erythema purpuricum every winter for five years, with swelling of the feet and legs. Erythema purpuricum may go on to necrosis of the hæmorrhagic lesions, as exemplified in a man, aged 40, who had had a previous similar attack, brought out, he admitted, when he drank beer, not wisely but too much, no doubt. Here it may be opportunely insisted on that alcoholism is an unfavourable factor. The necrotic areas had given rise to scars, especially about the knees, that might well have been taken for old syphilitic lesions, a point of some differential diagnostic interest. A very unusual erythema purpuricum, which appeared to be due to the action of strong sunlight, was observed in a woman, aged 23, in whom the face was first affected and then the forearms. The aforementioned examples will suffice to bring out the point I desired to insist on, viz., the divers causes leading to one and the same symptom, a phenomenon of importance, I may add, in cutaneous pathology. The reverse of this is the fact that various skin manifestations or reactions may be due primarily to one and the same cause.

A more severe and rare condition is the one known as peliosis or purpura rheumatica (of Schönlein), which is here in its place after discussing hæmorrhagic erythema multiforme. In peliosis rheumatica the pains in the joints are marked, and they may be preceded or followed by the cutaneous hæmorrhages, especially about the joints. The patient is ill generally, and looks it. The temperature may or may not be raised, although in the latter case the hæmorrhagic manifestations and other symptoms may be just as severe. The absence of pyrexia must not mislead the observer, for it is in this morbid condition that it is of the greatest importance to bear in mind the possibility of serious internal hæmorrhages, which may prove fatal. In one case I observed death was the result of intestinal hæmorrhage.

Whether the qualification rheumatica is a correct one or not is a point that must be discussed. It is now so well known that many infections may lead to joint symptoms quite apart from rheumatism proper, as in gonorrhœa, for instance, that it behoves us not to use the term rheumatica in a loose way. All cases of so-called peliosis rheumatica are not specifically rheumatic in origin, but the fact remains, nevertheless, that hæmorrhagic rashes may occur in the course of acute rheumatism. Moreover, valvular cardiac lesions have been noted as a result apparently of peliosis rheumatica, so it is stated, in the absence of the general symptoms denoting acute rheumatism. Again, peliosis rheumatica has been associated with endocarditis, and although the latter has been shown to arise from various causes, the rheumatic infection must be kept in view. In practice too, salicylates have appeared to do good.

(a) A Paper read before the West London Medico-Chirurgical Society, 1907.

In other cases that come before one, and no doubt allied to the preceding, the rash may be much milder in degree, and yet the visceral hæmorrhages may be so severe as to endanger life and even to prove fatal. Here the gastro-intestinal symptoms dominate the scene, and are always an indication for caution, as an opinion must be formed not so much on the appearances of the skin as on other factors. I need scarcely emphasise the importance of dealing with cases on their individual merits, and of avoiding concentration of the attention on the skin alone.

Closely allied to the purpuric erythema I have described is the condition known as urticaria hæmorrhagica or purpura urticans, in which the urticarial wheals become hæmorrhagic. The cutaneous rash may be associated with urticarial manifestations involving mucous membranes, with hæmorrhages from the latter that may be copious. Internal hæmorrhages may occur in some cases without hæmorrhages in the urticarial wheals.

I must now consider another clinical condition which is not uncommon, the so-called purpura simplex, sometimes alluded to shortly as purpura. Here the lesions are not raised as in erythema hæmorrhagicum, but level with the skin. It is often a very recurrent complaint, going on for years, with intervals of freedom. The lower limbs are mainly affected, and the pigmentation left behind may be very great. In a young woman aged 29, for instance, who had suffered from the complaint for about twelve years, the legs were of a dusky sepia brown tint. It is true that she had had arsenic for some months, so that drug may have played a part in the production of the pigmentation. In this case there was a presystolic thrill and the catamenia were excessive. When she took tonics she bled from the nose.

In another case the purpura about the ankles was accompanied by swelling. The patient had been subject to epistaxis from childhood. The catamenia were more or less menorrhagic. On examining the urine I found albumen but no blood either microscopically, chemically or spectroscopically. The discs were normal, but in one fundus there was a white patch. I could adduce other cases to show that purpuric rashes are not infrequently associated with albuminuria. That is why I have insisted on the importance of always testing the urine, and I may add whether the patient be adult or child, for I have seen the association in the latter. I say association, although the albuminuria is in some cases, no doubt, the determining cause of the purpuric rash, other factors being favourable, the possibillity of both manifestations being the result of an intoxication must not be overlooked.

The typical petechial rash due to flea-bites must be mentioned here. In children it may be so generalised as to be mistaken sometimes for a purpuric eruption from within.

Purpura hæmorrhagica or morbus maculosis Werlhofii takes us on a further stage. This is a very serious condition, in which the cutaneous hæmorrhages are extensive and accompanied by marked and varied internal hæmorrhages, so much so that all the viscera and mucous membranes would require to be enumerated. Epistaxis may be a prominent feature, and careful plugging of the nasal passages become imperative. The skin hæmorrhages are very recurrent, so that when cases have gone on for some time, the integument may present a multicoloured appearance as a result of involuting and evoluting lesions. Notwithstanding the severity of the symptoms, patients, generally children, may recover, but owing to the anæmia and collapsed condition, convalescence is necessarily protracted. Fortunately the disease is uncommon. Morbus maculosis has been looked upon as a diathesis, an easy way of getting out of the difficulty, but I propose to touch further on this point when I deal with ætiology, as in my opinion the condition is not an entity, but the manifestation of a reaction of the tissues dependent on a variety of causal factors.

Severe forms of purpura have been variously described under the names of acute idiopathic purpura vel angiohæmatic typhus, primary hæmorrhagic purpura, and so forth. Mathieu classifies these under three heads: the typhoid form, the hyper-acute form, and the pseudo-rheumatic form [1]. But it is difficult to resist the impression that these attempts at watertight classifications are subjective artificial creations, useful, no doubt, yet as sign-posts not to be too implicitly relied upon. Here once more, it is of essential importance to be guided by what one can observe for one's self in the way of facts discoverable by careful examination. In addition to this, those who have been much in contact with morbid conditions can gather a good deal of preliminary knowledge as to a patient's state by the impression made on the observer.

In children, Henoch has described a fulminating form, purpura fulminans, in which large cutaneous extravasations occur suddenly and rapidly spread, so much so that in a few days a whole limb may be involved, with darker areas interspersed, as of threatening gangrene. There may be slight fever or none. The skin hæmorrhages increase, and death soon closes the scene. In the new-born cutaneous hæmorrhages may occur, purpura neonatorum, as a result apparently of the sudden changes in the circulatory apparatus brought about by separate existence.

Hæmorrhages into the skin, mainly affecting the lower limbs, occur in scurvy, which is sometimes arbitrarily alluded to either as sporadic, or again as true scurvy, an artificial distinction. An instructive case of scurvy which was under the care of Dr. Seymour Taylor in the West London Hospital, and described by him at length in the transactions of the West London Medico-Chirurgical Society, will, no doubt, be remembered by some of you [2]. In that patient, a woman, aged 51, the cutaneous hæmorrhages involved not only the legs but also the face, trunk and arms, evidence of the severity of the disease. At the end of his paper Dr. Taylor remarked that it was sometimes difficult to decide where purpura ended and scorbutus began, and notwithstanding that text-books taught that they were separate and distinct diseases, he was sometimes led to think that they were but varieties of the same blood disorder, and that the symptoms and signs might vary according to the severity of the attack. From my own observations I agree with most of the views expressed by him, and I have already called your attention to my opinion in this respect. But I do not think that the conditions referred to by him need necessarily be varieties of one and the same blood disorder. The cutaneous manifestations, varying in degree, may well be on the contrary the result of a variety of blood disorders. I have already mentioned the case of a girl with recurrent erythema purpuricum—in whom a vegetarian diet appeared to be one factor at any rate in the causation of the cutaneous hæmorrhages and account for her somewhat cachectic general condition. The more I see of these hæmorrhagic symptoms the more I am struck by the complexity of this problem of causation, a subject I shall have to touch upon when dealing with ætiology. In this place I should like to insist again on the importance of not taking diseases considered as entities too literally, especially from the point of view of treatment. What we have to deal with in the majority of the cases I am considering, is an organism with all its potentialities labouring under some intoxication or infection, a fact which will become more and more evident as we go on.

I may suitably refer here to the cutaneous hæmorrhages which arise either before, or in the course of, or after various morbid conditions.

Let us take enteric fever for instance. In the case of a boy, aged 19, a generalised petechial rash occurred sparing a triangular "bathing drawers" area, typical rose spots being present at the time. Widal's reaction was positive. Or, again, one may observe large areas of ecchymosis.

Purpura may follow diphtheria. In the case of a girl, aged 11, recorded by Goodall and Basan [3], there were cutaneous hæmorrhages about the limbs but very little on the trunk. No albuminuria. True it is that antitoxin had been injected, but Goodall did not consider that was the cause, as he had seen the same symptoms in a case before antitoxin was introduced. I have pointed out that Trousseau noted these hæmorrhages in diphtheria long ago: petechiæ, ecchymoses and epistaxis [4].

As is well known hæmorrhagic lesions may occur as part and parcel of the acute exanthemata, in variola hæmorrhagica for instance. Varicella hæmorrhagica is of very rare occurrence. In measles, hæmorrhagic foci may appear about the skin, going on to necrosis, especially where septic endocarditis is a complication. With regard to small-pox, a petechial rash is sometimes observed at the end of the first stage of the disease, that is, at the time the true eruption appears, or should do so. It is of bad prognosis. Again, cutaneous hæmorrhages may be interspersed between the papules or vesicles of the efflorescence. In this connection the finely punctate petechial rash recorded by Roger under the name of purpura minutissima metamerica [5] must be alluded to as of differential diagnostic importance. The case was that of a woman, aged 34, and the rash being accompanied by symptoms resembling those of variola, the question of the latter disease arose. The purpuric rash commenced in the groins and axillæ, and also about the joints, ultimately becoming generalised in a way that strongly suggested a spinal origin, hence the term metameric or segmental. Further observation showed the case was not one of variola, although at first the differential diagnosis from a premonitory purpuric rash appeared likely. It should be added, too, that the case had been sent to the isolation fever hospital under the diagnosis of scarlatina.

A purpura-like eruption in scarlet fever has been noted by Heubner [6] in a child, aged 1½, the whole of whose body was covered with lentil to thaler sized patches, not disappearing on pressure. Here and there the rash was more stippled. The child had not been isolated as a scarlatina case, as the condition was thought to be one of "septic" rash. Hubert Biss has given a good account of a purpura fulminans following scarlet fever [7] in a boy aged 3½, who had received 24,000 units of antitoxin under the idea the case was one of diphtheria. But Biss considered it was highly improbable that this was the cause of the widespread pin-point hæmorrhagic rash which supervened, and which was preceded and accompanied by other hæmorrhages (stomach, rectum). An abundant growth of streptococci was obtained from the tonsillar exudation. The child died thirty-six hours after the appearance of the first hæmorrhages. The kidneys were found to be transformed almost entirely into fat. I have mentioned this case at some length on account of the complexity of the factors present: scarlatina, antitoxin, streptococcal infection and useless kidneys. The condition described appeared to Biss to come into the category of the purpura fulminans of Henoch I have referred to, and it must be noted that one of the latter's two cases occurred after scarlet fever [8], as did also one of two cases related by Ström and Alexander [9], but I may point out that in Henoch's cases, and in two others he cites (Michaëlis and Charron), there were no hæmorrhages from mucous membranes and the necropsies were negative. Rice-Oxley and Cullen have also recorded similar cases.

Cutaneous hæmorrhages have also been seen as a complication of vaccination [10].

In erythema nodosum, which appears to be a disease *sui generis*, cutaneous hæmorrhages may be a complication.

As to the syphilitic infection, the condition known as syphilis hæmorrhagica neonatorum appears to have been first established as a fact by Behrend [11]. The clinical picture is made up of cutaneous and internal hæmorrhages, the latter involving various organs. But in adults hæmorrhages occurring in the skin during the early or so-called secondary period are uncommon. Piccardi has described an instructive case, with histological details, the subject being a man aged 38 [12]. Microscopically there were infiltrations of extravasated red blood corpuscles. In another case recorded by Weitz, he could not demonstrate hæmorrhage into the tissues, but only marked dilation of the small vessels, which were packed full of red corpuscles. This explained why the cutaneous lesions did not disappear on pressure [13].

Cutaneous hæmorrhages with hæmorrhagic bullæ may occur in the course of enteric fever in syphilitics under mercurial treatment. In a case of this kind under Robin, enteric supervened in a woman aged 25, whilst under energetic mercurial treatment for early syphilis, death closing the scene soon after the appearance of skin hæmorrhages. Duhot observed a man in whom enteric developed a month and a half after a course of mercury. Towards the end of life petechiæ occurred followed by ecchymoses and hæmorrhagic bullæ [14].

In addition to the infectious morbid conditions I have enumerated, purpuric rashes have been observed in connection with many others, such as typhus, cholera, puerperal fever, malaria, and so forth. Petechial and purpuric spots are apt to appear in epidemic cerebrospinal meningitis or spotted fever. In this disease, as you well know, the diplococcus meningitidis intracellularis is found in the cerebrospinal fluid, but I desire to allude to it mainly in connection with the important part supposed to be played by the spinal apparatus in toxic erythematous and hæmorrhagic rashes, a point I have called attention to when speaking of Roger's metameric purpura minutissima case.

Various micro-organisms have been found in purpuric eruptions. I have dwelt on some already. In the list are found streptococci and pneumococci, less frequently, the staphylococcus, bacillus anthracis, bacillus pyocyaneus and others. With regard to this point I propose to deal with it further under ætiology. I should like to say at once, however, that saprophytic micro-organisms may find their way into the blood after death, and also no doubt during life, so that their presence does not conclusively prove in certain circumstances that they are the cause of the hæmorrhages.

Again, cutaneous hæmorrhages occur in cachectic states, such as those which follow in the train of cancer, sarcoma, pernicious anæmia, etc.; also in various visceral diseases, especially of the liver and spleen [19]. In this connection may be mentioned the purpura senilis described by one of the fathers of English dermatology, Bateman, a condition observed in the aged.

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THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

A Case of Congenital Syphilitic Osteo-Periostitis of the Femur of an Infant.

By J. B. Legg, M.S., F.R.C.S.

A male infant, 5 weeks old, was brought to the hospital with a swelling in the lower part of the left thigh. It had been noticed on the previous day whilst the child was being washed. The child was said to be rather more fretful than usual. There was no history of injury either at his birth—the presentation was a vertex and the labour was easy—or since. The mother had had one miscarriage and one child, who died soon after birth. There was no other definite syphilitic history. This baby was a rather poorly nourished child, but appeared otherwise healthy. There was no rash, no condylomata, and he did not snuffle. At the lower part of the left thigh, involving the whole circumference of the shaft of the femur, there was a uniform, smooth, hard swelling, with shelving edges, at the upper end. The skin and subcutaneous tissue were unaffected. The swelling was apparently tender, and it reached half-way up the shaft a little further on the inner side, where it was more prominent. The knee was kept in a flexed position; the infant did not move the leg, and attempts to flex or extend the knee caused the child to cry a good deal. If he was left alone, he lay quietly and was not fretful. The knee joint appeared to be unaffected. The temperature was 99.6°. All the other bones appeared to be healthy. The diagnosis, Mr. Legg said, lay between some form of inflammatory swelling and a new growth. An infant of this age was very unlikely to be the subject of a new growth: inflammatory swellings were not uncommon, and therefore until it had been proved not to be inflammatory, the question of new growth need not be further discussed. The characters of the tumour were in favour of it having been present much longer than the mother had observed. If it was an acute inflammatory swelling of the bone, and had reached the size of the present tumour, the tenderness would have been much greater, there would have been redness of the skin and œdema of the subcutaneous tissue, a greater rise in temperature, and the child would be very ill. All these signs were absent. Moreover, a leucocyte count showed only 8,200 per c.mm. For these reasons an acute infective process could be excluded. A spontaneous subperiosteal hæmorrhage was a possibility, but the child was not anæmic, and its gums were healthy. There remained practically three things, (a) a fracture, (b) tuberculous periostitis, (c) osteo-periostitis due to congenital syphilis. As regards a fracture there was no normal mobility and no suspicion of crepitus, and no history of injury at or since birth. A skiagram would be of value in excluding such injury. The diagnosis really lay between tuberculous and syphilitic osteo-periostitis. Tubercle in an infant of this age was rare in the bones: congenital syphilis was not rare, and affected the ends of the long bones, specially the humerus and femur leading to the condition known as "pseudo-paralysis," in which the joint is not moved on account of the pain, but when the pain disappears and the bone condition recovers, the paralysis also disappears. This child at present showed no other sign of congenital syphilis. Therefore, one would have to try the effect of treatment to confirm or disprove the diagnosis. It was important to remember that congenital syphilis showed itself in many ways, and there was not always present the whole picture of the disease. Unguentum hydrargyri was ordered to be rubbed in to the abdominal or chest walls, at first once and then twice daily. A very important element was that the child should be kept warm and well fed.

The child was admitted as an in-patient. A skiagram did not show the presence of a fracture. In the course of the next three weeks, under the above treatment, the swelling almost completely disappeared, the general health being much improved at the same time.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

Encephalocele.—Mr. Peyton Beale operated on a child, æt. about five months, who had been admitted under Dr. Still with a large soft tumour, somewhat larger than the child's head, projecting from the occipital region, about two inches below the occipital protuberance. The tumour was soft in consistency, and became larger when the child cried. Its point of attachment to the skull was about two and a half inches in diameter, and on carefully examining the occipital bone with the fingers it was clear that the tumour issued through a foramen of about an inch and a half in diameter in the occipital bone. The child was fairly well nourished, but for the last few days had been taking food badly, so it was determined to make an attempt to remove the tumour. After the usual preparation, a vertical incision was made straight over the mass, which was then seen to be an enormously distended ventricle covered with cerebral and cerebellar substance. A strong ligature was rapidly applied round the pedicle of the tumour, and the latter cut off. It was then seen that it was an expansion of both lateral ventricles, but it was not clear exactly what part was beneath the cerebellar substance. The stump was then ligatured in three or four smaller pieces, and the redundant skin having been removed with scissors the edges were sutured vertically. The whole operation lasted only a very few minutes, and the child appeared none the worse for it, indeed it took nourishment better during the next week. It then developed some bronchitis, and died suddenly about a fortnight after the operation. Mr. Beale remarked that these cases when they were operated upon usually died very soon from shock; he believed, however, that this could be avoided if the operation were done quickly. In this particular case there was no reason to suppose that the child died as the result of the operation, and had the bronchitis not supervened it would have been very interesting to observe to what extent the child was deficient as regards general and special sensation and motion as the result of the loss of so large an amount of cortical brain substance. As far as could be determined in this child there was no impairment whatever with reference to sensation and motion, at any rate as far as its age rendered it possible to carry out an examination on these points. He said one of the reasons for operation was the rapid increase in size of the tumour, which could not be kept in check by tapping.

ROYAL SOUTHERN HOSPITAL, LIVERPOOL.

A Case of Recurrent Intestinal Obstruction.—Mr. Newbdlt operated upon a woman, æt. 66, who had previously been subjected to three abdominal sections for intestinal obstruction. The first operation was done for a large umbilical hernia fifteen years previously. The second nine years afterwards for a recurrence of the hernia with obstruction, and the third five years ago for obstruction due to matting and binding down of the intestines in the hernial sac. On admission she had a feeble pulse counting 96 to the minute, was vomiting constantly, and complained of intense colic pain. There was a large umbilical hernia, and palpitation caused the intestines to contract, giving rise to an intense colicky. Flatus was passing. From a previous knowledge of her condition it was probable that there was again a matting together of coils of intestine, giving rise to a partial but not complete obstruction. A long median incision was made, and the hernial sac laid open; coils of small intestine were found adherent to the sac and to one another. They were carefully separated from the walls of the sac, but during this process the wall of the gut was denuded of peritoneum in several places, and bleeding points had to be secured. When this separation was complete the gut was returned into the abdomen and the redundant sac excised. As the patient's condition remained good the coils of intestine were withdrawn loop by loop from the abdomen, and separated from one another. Each coil was then taken, and the denuded surface sewn over wherever it was possible to do so without narrowly constricting the lumen of the bowel. Saline was poured into the abdomen and the wound closed in the ordinary way. With the help of salines and strychnine the patient rallied well, and her bowels acted freely two days after operation. No morphia was given; her colic disappeared, and she went home three weeks after this her fourth operation eating well and feeling quite comfortable. Mr. Newbolt remarked that the four operations had all been performed in the Southern Hospital, the first by Mr. Robert Jones, and the last three by himself. Of these the second and third had to be performed hastily as the obstruction was complete and the intestines were distended. At this the last operation there was not much distension, but the vomiting and intense colic were the chief symptoms complained of. Resection of the adherent coils was out of the question, as too much bowel was involved, and the patient's condition did not justify so severe a procedure. Entero-anestomosis would have shut off a large portion of the small intestine. The patient, once a stout woman, had grown thin from malnutrition, due to her inability to take solid food. He hoped that the repair of the denuded intestine would relieve her symptoms in the future.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Obstetrical and Gynæcological Section.

Inaugural Meeting of this Section, held October 10th, 1907,

The President, Dr. Herbert Spencer, in the Chair.

Dr. **Amand Routh** reported a case of Cæsarean Hysterectomy for Atresia vaginæ. The patient consulted him at Charing Cross Hospital in March, 1906, a fortnight after delivery, for incontinence of urine. He then found that the anterior portions of the vaginal and supra-vaginal cervix had been torn away with the roof of the vagina and base of the bladder. He successfully repaired the bladder injury, and in three months' time the woman became again pregnant. She again came to the hospital in July this year, being then actually in labour. Finding that there was much vaginal atresia, and that if labour proceeded, further irremediable injury would be caused to the bladder, Dr. Routh removed the child by Cæsarean section, and the uterus by sub-total hysterectomy. Both mother and child recovered without further incidents. Dr. Routh advocated Cæsarean Hysterectomy in all such cases, and gave a table of 30 similar cases in which it had been performed, with a mortality of 20 per cent. In the 11 cases where the stump was treated by the intra-peritoneal method all the mothers recovered.

The **President** said he agreed with the author that the extensive cicatrization involving the bladder furnished a clear indication for Cæsarean section, to be followed by hysterectomy. He had seen very extensive vaginal cicatrices yield to the pressure of the head in natural delivery, but in Dr. Routh's case this would have entailed great risk of injury to the bladder. He would prefer total hysterectomy, if practicable, to supra-vaginal hysterectomy, on account of the free drainage which it afforded.

Dr. **Tate** read a short communication on a case of Œdematous Fibroma of the Pelvis. The patient was a married woman, æt. 39, who had had five children. Since the last confinement, six years ago, she had noticed enlargement of the abdomen. On admission into St. Thomas's Hospital the lower part of the abdomen was found to be occupied by a very ill-defined swelling. To the left of it the uterus could be made out the size of a duck's egg. Abdominal section was performed, and the tumour was found to consist of a large flattened œdematous mass, covered with peritoneum, and embedded in the pelvis. After securing many large vessels the tumour was removed by enucleation. The cavity thus left was packed with gauze, and the uterus then removed. The ends of the gauze plugs were brought out through the vagina, and the peritoneum brought together so as to cover up the large cavity in the pelvis. The patient had two attacks of secondary hæmorrhage, and subsequently some sloughing of the walls of the cavity occurred, but she ultimately made a good recovery. Dr. Tate found it difficult to say in what structures the tumour originated, but it certainly had no connection with the uterus. Mr. Alban Doran asked if the fibroid removed chiefly occupied the mesosalpinx or mesometrium, the portion of the broad ligament below the level of the ovary. In Mr. Doran's own case, published in the 41st volume of the "Transactions of the Obstetrical Society of London," the bulky tumour lay between the folds of the mesometrium without opening up the mesosalpinx, so that the Fallopian tubes and ovaries lay free on the upper surface of the tumour. When removing a fibroid by enucleation from the mesometrium the surgeon must remember that the ureter may run above it, though as a rule it runs below the tumour, in which case it may be firmly adherent to the lower surface of the new growth.

Prof. **W. E. Dixon** and Dr. **Frank E. Taylor** gave an Epidiascopic Demonstration on the Physiological Action of the Placenta. They set forth the results of an investigation in which they are engaged into the physiological effects which result from the intravenous injection of placental extracts into cats, rabbits, and dogs. The extracts were made by mincing fresh normal human placentæ, extracting with absolute alcohol, evaporating to dryness, and taking up the residue in saline solution. A series of tracings showing the results they obtained were projected on to the screen by means of the Epidiascope, and the effects of intravenous injection of placental extract on the circulation, the intestinal volume and movement, and on the uterus were demonstrated. There was a striking rise of blood pressure, following a preliminary fall, on injection, which was chiefly due to constriction of the peripheral arterioles. The general effect on the circulation was very similar to that produced by adrenalin, but differed from this in three ways: (1) A less rapid rise of blood pressure; (2) a more prolonged rise, and (3) a less marked cardiac effect. Intestinal volume was decreased, and its movements were inhibited. In the uterus the results differed in the pregnant and non-pregnant condition. In the pregnant uterus there was an increased tonus of the uterine musculature, together with a well-marked increase in its rhythmic contractility. They concluded that the placenta produces a chemical substance, which develops with the ripening of the placenta, the liberation of which, by contracting the uterus and the vessels, may induce the onset of normal labour.

The **President** thanked the authors for the interesting and valuable demonstration they had given, and he hoped that many more papers dealing with experimental work would be read before the Section. He asked whether the authors' results tallied with those of Acconci, who had written somewhat extensively on the subject of placental extracts. Acconci's work, "Researches on the formation of the placentine from placental extracts," published in 1906, had just come into his hands, so that he had not had time to master its contents. He thought the authors, in "suggesting a tentative hypothesis," were wisely cautious in drawing conclusions from their experiments.

Dr. **Macnaughton-Jones** said that watching the results of the experiments on blood pressure, and seeing that the increase appeared to be greater than that of adrenalin, placentine would probably prove a valuable physiological agent for administration previous to anæsthetization in serious abdominal operations, the more so now that the scopolamine, morphia, and chloroform method was frequently adopted. Since he (Dr. Macnaughton-Jones) had seen Prof. Schägers' paper and Mr. Scharlieb's experiments conducted in Edinburgh some few years since, he had always used strychnine and atropine for the same object. This, of course, was a collateral issue arisng out of the paper.

Dr. **Amand Routh** alluded to his case of "Parturition during Paraplegia" (published in 1897 in the "Obstetrical Society's Transactions," Vol. xxxix.), where the spinal cord has been destroyed by injury in the Dorsal Region five months previously. Dr. F. W. Mott and he had suggested that labour was, partly at all events, induced by the metabolism of the pregnant uterus. That case clearly proved that lactation, which was normal, could not have been induced by reflex nervous action, for the spinal cord was destroyed between the nerves going to breasts and uterus, and Dr. Routh then pointed to a bio-chemical cause arising in the uterus as being the probable exciting cause, acting through the blood. Had the authors experimented in this direction by noting the effect of the injection of placental extract upon mammary gland activity? He agreed with the authors that perverted metabolism might produce an autotoxæmia, which might cause albuminuria, acute yellow atrophy of liver, insanity and hyperemesis gravidarum.

Dr. **W. S. A. Griffith** said that the thanks of the Section were due to the authors for the paper, for the facts which they had brought forward were the result of laborious research. He could not however accept the chief conclusion which they had drawn from these facts, for which there appeared to be no evidence whatever, viz., that a substance contained in the placenta, though ascertained to increase uterine contraction, was the cause of labour either premature or full time. The question of the nature of the labour pains, as distinguished from the contractions which are known to occur throughout the active sexual life of a woman, and are so obvious during the course of pregnancy, was too large a one to attempt to discuss on that occasion. It appeared to him that the contractions of pregnancy are comparable to the colicky pains of contraction of the bowel unrelieved, and that the essential difference in each case consists rather in relaxation of the orifice than of a new form of contraction. There are many agents which increase uterine contraction, but which are almost useless for the indication of labour.

Dr. **C. Nepean Longridge** asked Dr. Taylor if the induction of labour was a long process in the case of induction at thirty-six weeks, in which he found the placental extract was very active. He mentioned that he had found a definite and progressive rise of blood pressure in a moderate number of primigravidæ during the latter months of pregnancy. He also referred to the theory of Dr. Blair Bell that labour was brought about by the accumulation of calcium in the blood. But since calcium was practically insoluble in alcohol it could not be a constituent of the extracts which Dr. Taylor had used in his experiments. One could not however deny that calcium salts had anything to do with the matter, because there are so many examples in which vital activity depends on the interaction of organic and inorganic substances in the body.

The following specimens were shown:—

(1) Chorion epitheliome of the uterus with metastasis in the vagina lungs, liver, and brain, by Dr. T. W. Eden.

(2) An instrument, by Dr. R. Wise.

(3) A pregnant uterus with fibroids, by Mr. J. Bland-Sutton.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting Held at Liverpool, Oct. 18th, 1907.

Dr. E. O. **Croft** (Leeds), President, in the chair.

INTRALIGAMENTARY BLADDER.

Dr. **W. E. Fothergill** (Manchester) mentioned the case of a single lady, æt. 28, who complained of a bladder trouble dating from puberty. For about five years micturition was necessary every hour or so to relieve intense pain in the left iliac region. None of the usual causes of bladder irritability could be found. The uterus could not be retroverted and appeared to be attached to the back of the bladder, and to dig into it as soon as two or three ounces of urine had accumulated. The abdomen was opened, and it was seen that the utero-vesical pouch was practically absent, the bladder with the small anteflexed uterus lying between the layers of the broad ligaments. The peritoneum over the fundus of the bladder was incised and the organ separated from the uterus. The peritoneum was united from side to side, so that the line of suture was antero-posterior, a utero-vesical pouch being thus formed. The fundus uteri was fastened to the peritoneum in the lower angle of the abdominal wound, to keep the uterus from pressing on the bladder. The patient a year after the operation had greatly improved in health, and had lost the pain which previously accompanied the distension of the bladder. The organ, however, was still irritable at times. Menstruation, which previously was rare and scanty, was now regular and profuse, and the uterus had gained in size and tone since it was set free from the bladder.

POST-CLIMACTERIC HÆMORRHAGE.

Dr. **Archibald Donald** (Manchester) communicated a case of unusual post-climacteric hæmorrhage occurring in a woman aged 66 years, who had one child 38 years ago. Menstruation, which began at 13 years of age, was normal and regular up to age 39, *i.e.*, 27 years ago. For 16 years there was no discharge of any kind, then irregular hæmorrhage began at variable intervals. The flow would last from two to ten days, and was not attended by any pain. The patient was markedly anæmic, and the face presented a striking appearance, being of a lemon-yellow tinge. The pulse was 90 per minute, and there was a diffuse præcordial pulsation. Bi-manually the uterus was the size of a 3 months' pregnancy. Vaginal hysterectomy was performed on May 18th, 1907, and the recovery was uneventful. On opening the enlarged uterus, its cavity contained a growth apparently originating in the endometrium, but invading the musculature. Microscopically, cylindrical down-growths of epithelial-like cells invaded the muscular wall. Professor Lorraine Smith pronounced it to be an endothelioma, probably originating in the lymph spaces of the endometrium, or body of the uterus.

A paper on the

PATHOLOGY OF SOLID OVARIAN TUMOURS

was read by Dr. Briggs and Dr. T. E. Walker. In the hospital and private practice of the former during 20⅓rd years 488 ovarian new growths were removed by operation. They were arranged in two groups, the cystic group of 439 including 284 adenocystomata, 44 dermoids, 36 broad ligamentcysts, 24 papillomata, 50 carcinomata, 1 perithelioma (sarcoma),

And the solid group of 49, including 31 ovarian fibromata, 3 fibromata of the ovarian ligament, 3 adenomata, 1 surface papilloma, 8 solid carcinomata, 1 solid teratoma (myxo-chondro-sarcoma), 1 cellular spleen-like tumour.

In the cystic group Dr. Walker, during a recent research, had found 50 ovarian carcinomata and 1 ovarian sarcoma (perithelioma). The rarity of cystic sarcoma was alluded to, and compared with the statistics of Veit and Martin, and with the general statements found in text-books. The paper was otherwise exclusively confined to the solid tumour group. Thirty-one fibromata in 488 indicate the occurrence of these tumours in 6.4 per cent.; the common text-book statement is 2 per cent. The wide range of structure observable amongst these tumours, from the structureless, or almost structureless, calcified fibroma to the highly cellular new growth was pointed out, and especially in reference to the latter a brain-like tumour and a spleen-like tumour, each of large size, were specially dealt with. The former consisted of round cells, and looked suspiciously sarcomatous when removed in March, 1897, from a girl aged 15½; this patient is now alive and in vigorous health at the age of 26; the spleen-like tumour as the after-history of the patient attested, was also innocent. The former was included in the fibromata, but the latter contained so little tissue apparently fibromatous that it was placed in a separate table, under its own briefly descriptive heading of a cellular, vascular spleen-like tumour. These features, however, were exceptional in the structure of ovarian fibromata. The common fibromatous tumours in the series consisted of spindle and round cells, embedded in a fully formed fibrous interlacement in varying proportions.

The position of the ovarian fibroma amongst solid ovarian tumours was now well estblished, and was no small tribute to the work of Leopold, published in 1874.

The fibromata included in the paper were arranged under the accepted forms of ovarian fibromata, 15 diffuse, 9 circumscribed, and 7 pedunculated. The diffuse, the most numerous, was bilateral in 2 cases, and in 7 instances the patient was beyond the menopause. Of the total the menstruation was absent in 2 diffuse and in 1 circumscribed; otherwise it was regular in 4 diffuse, 3 circumscribed, and 4 pedunculated; irregular in 1 circumscribed, diminished, in 1 diffuse. Pregnancy, in 2 cases, both circumscribed, was undisturbed by the operation. The pedicles were twisted in 1 diffuse, 1 circumscribed, and 1 pedunculated. Ascites was recorded as present in 13, absent in 18. It was least frequent with the circumscribed tumour, being present in 2, absent in 7; with the diffuse form, absent in 8, present in 7; with the pedunculated, present in 3, absent in 4. Its ætiology was considered. The fibromata of the ovarian ligament and the valuable work of Doran in this connection was alluded to.

A solid teratoma, a rare surface papilloma, and a round-celled sarcoma were each described and illustrated.

The rest of the paper consisted of a report by Dr. Walker on the solid adenomata, of which there were 3 cases, and on the solid carcinomata, of which there were 8 cases, 7 bilateral, and 1 unilateral. Of the 7 bilateral, 6 were definitely secondary, 2 to primary scirrhus of the breast, and 4 to growths in the large bowel. In the 7th case, in a woman aged 48, the primary growth was unknown, consequently it was excluded. Six-sevenths of the evidence was in support of Bland-Sutton's conclusions, that solid bilateral carcinomata are secondary.

The case of unilateral carcinoma was described.

The secondary tumours above referred to, reproduced the structure of the primary growths—scirrhus carcinoma, colloid carcinoma, and adeno-carcinoma.

OPTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

FIRST MEETING OF THE SESSION, HELD ON THURSDAY, OCTOBER 17TH, 1907.

The President, Mr. R. MARCUS GUNN, F.R.C.S., in the Chair.

THE PRESIDENT'S INTRODUCTORY ADDRESS.

MR. GUNN first tendered his warm thanks to the Society for the honour implied in his election to the presidential chair, and assured the members that he yielded to none in feelings of loyalty to the Society, whose interests he would do his best to serve. The first portion of the address was devoted to a review of the history of the Society, dating from the issue of a circular letter in February, 1880. He referred to the most important contributions to the Transactions, under various headings—physiological, surgical, clinical, pathological, etc.

Passing on to the future, he said an exact knowledge of the ætiology of affections of the cornea, iris, and choroid was much wanted, while they awaited an explanation of recurrent retinal hæmorrhages in eyes otherwise seemingly sound, in persons whose general health was not manifestly at fault. If a diminished coagulability of the blood were found to be present, and that was kept at bay, it was reasonable to expect that the recurrence due to that cause would be checked; but such treatment had been disappointing. Opacities in the lens occasionally presented forms which did not seem inexplicable at all by our knowledge of its anatomy or its nutrition. Could those be accounted for?

Prognosis was a very important matter to the patient, yet it was often uncertain, and must continue so. Yet if the ophthalmic surgeon knew a little more of the true nature of the different diseases which he had to treat, his knowledge of their course and duration would be materially increased. In the past few years a great advance had been made as to the nature of infective agents, and the ways in which the body attempted to free itself from invasion. There was the whole army of bacterial poisons, with their anti-bodies, and ophthalmic surgeons must know sufficient to be able to intelligently follow the reason involved in serum and vaccine therapy. If it was useful in their specialty, they must inquire when and how far, and how it should be employed. With regard to medicinal treatments, he hoped they would keep their armamentarium as small as possible without the sacrifice of efficiency. Too many drugs were a weariness of the flesh, both to him who gave and he who took.

He thought the Society might well revert to more frequent committees and discussions, as in the earlier history of the Society. He referred to the large number of card specimens now shown before the Society, many of them of great interest and importance, but members did not seem able to take full advantage of them, and their very number was the cause of that inability, for they could not see all, if, indeed, they could see any, satisfactorily in half an hour in a crowded room. The institution of clinical evenings was quite an advance, but much still remained to be done. It would be well to have standing committees for men interested in special lines of work, whose duty it would be to report upon any case when the member showing it approved. Of such committee the exhibitor would be a member for the time being.

Mr. J. B. LAWFORD read a paper entitled

A CASE OF TUMOUR OF THE OPTIC NERVE.

The patient was a female, æt. 38, single, who came under observation in June, 1906. The eyelids on the left side were puffy and slightly red; there was a moderate degree of proptosis, the displacement being almost directly forwards. The movements of the eyeball upwards and outwards were restricted, rotation downwards and inwards full. No œdema, and but slight vascularity of the conjunctiva. No tenderness on pressure; nothing abnormal in the orbit; no pain, but some discomfort. Vision was reduced to perception of light. The media were clear, the optic papillæ ill-defined and pale, and the retinal veins tortuous. No hæmorrhage or disease of the choroid. The family history was good, the patient was a healthy, robust woman, and tubercular and syphilitic disease could be reasonably excluded. There was no history of injury. Something amiss was noticed in the left eye four years previously, and in April of that year she consulted Mr. Wherry, of Cambridge, who recorded the vision on that date as follows: R. 6/6; L. 6/18, but with correction of hypertrophic astigmatism, 6/9 partly. The patient was seen by another ophthalmic surgeon during 1903-4, and was under treatment by drugs for some months, but there was no improvement in the symptoms. The diagnosis made in 1906 was (?) tumour of optic nerve sheath, (?) osteoma of orbit.

Treatment by iodide of potassium was advised, and was carried out for some weeks, but without benefit. In July, 1907, there was a slight but noticeable alteration, the proptosis had increased, the movements of the globe were much restricted in all directions, the pupil was inactive to light, and there was no perception of light. The patient could not state how long the blindness had existed. No hæmorrhages could be distinguished, the retinal veins were tortuous, there was no tenderness, no tumour could be felt, or deep pulsation detected by the finger. The proptosis could not be reduced by pressure. There was no severe pain. The general health did not appear to be prejudiced by the orbital disease. Operation was advised.

Three days later the patient was seen by Sir John Tweedy, who thought it was either osteoma of the orbital wall or tumour of the optic nerve, probably the latter. In June, 1907, the eyeball and tumour were removed. The tumour extended from the back of the eyeball to the apex of the orbit, and the nerve was divided as close to the optic foramen as possible. There was extensive hæmorrhage into the orbital tissue; the swelling gradually subsided, and she left the nursing home a fortnight after the operation. Fifteen similar cases had already been recorded, which was in contrast to the number of cases of primary intradural tumour of the optic nerve, which numbered 102 up to 1901. The age of his own patient was above the average.

The microscopical characters of the growth were described and demonstrated by Mr. George Coats.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Meeting held Friday, October 4th, 1907.

The President, Mr. Richard Lake, F.R.C.S., in the chair.

Mr. Lake read his Presidential Address on "Some Reflections on the Relationship of the more important points of Diseases of the Ear and Nose and General Medicine."

He dwelt upon points chosen to illustrate more particularly the effects of various constitutional complaints upon the ear and nose; and the effects upon the general state of the body when the ear and nose are affected.

LIVERPOOL MEDICAL INSTITUTION.

First (Inaugural) Meeting of the Session, Held Thursday, October 10th.

The President, Mr. F. T. Paul, F.R.C.S., in the Chair.

The President delivered an address on Abdominal Surgery.

On the proposal of Mr. Edgar A. Browne, seconded by Mr. Rushton Parker, the President was accorded a most hearty vote of thanks.

Subsequently the President entertained 150 members to supper and a smoking concert.

Dr. Hope reported to the Liverpool Health Committee on October 9th that the death-rate in the city for the past week was 18.1, as compared with 22.0 for the corresponding period last year. There were in the hospitals 624 cases, including 402 of scarlet fever, 12 of typhus, 51 of typhoid fever, 12 of measles, 53 of diphtheria, and 12 of phthisis. Mr. Jacob brought before the committee an offer made by the Hon. Nathan Strauss of New York, of a pasteuring plant for the preparation of milk for infants, and Dr. Hope having reported favourably on the matter, the committee, o nthe motion of Mr. Shelmerdine, seconded by Mr. Jacob, resolved to accept the offer, with thanks.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Oct. 20th, 1907.

Origin and Treatment of Cancer of the Stomach.

Carcinoma of the stomach sets in, according to Prof. Robin, in an insidious manner. It begins by anorexia, with a pronounced dislike for certain kinds of food, as meat and wine. The patient is seized with vomiting, which is one of the usual signs of carcinoma, and is caused by the seat of the neoplasm at the orifices, trouble in the gastric secretion, and the presence of the tumour itself.

The vomiting presents several varieties, the most characteristic is that observed in the morning fasting, or during the day, preceded or accompanied by a nauseous feeling, and constituted by watery liquids produced without effort as a simple regurgitation; it is the cancer liquid. At other times food is vomited several hours after meals, and procures great relief to the patient. The matter vomited has a sour and putrid odour. Hydrochloric acid is wanting, but acids in process of fermentation are abundant, due to the microbian organisms which are in constant development.

At a later stage of the disease black vomiting—colour of coffee grounds—sets in, and is due to the blood derived from erosion of the vessels of the morbid tumour.

Hematemesis, properly called, are rare in gastric cancer; they belong rather to ulcer of the stomach.

An important symptom is pain. It is very common, but has not the acute character of ulcer. The patients complain rather of a sensation of weight, with a few lancinating pains over the seat of the tumour, which is sensitive to pressure. This painful sensation does not entirely cease in the intervals of meals. It is not, however, immediately exasperated by the ingestion of food as in ulcer, but increases slowly during the digestion, when it is frequently complicated with pyrosis.

Constipation is the rule; diarrhœa is only observed in the advanced period of the disease. Palpation of the stomach reveals the seat of the neoplasm; when the organ is not distended the pylorus may be considered intact.

Analysis of the chemical composition of the gastric secretion can give useful information. Some time ago the absence of free hydrochloric acid was a pathognomonic sign of cancer, but this absence was demonstrated in a large number of other maladies, while in carcinoma an excess of this acid was sometimes observed. However, this absence has a certain importance in doubtful cases.

Physical signs should not be neglected. It is not the stomach alone that should be examined, but also the condition of other organs, as the liver, the omentum, peritoneum, or the umbilicus. Divers ganglions should also be sought for, especially above the left clavicle, which, if present, constitute a counter-indication to surgical interference.

The legs are frequently the seat of œdema, and sometimes of phlegmatia alba dolens, localised chiefly in the veins of the calf of the leg.

Sometimes fever exists to a certain amount, resulting from gastric fermentation, but usually passes unperceived. At other times, on the contrary, it reaches 104°, and is due to absorption of the toxic products.

As to treatment, condurango, chlorate of soda, iodide of sodium, methylene blue, bichromate of potash, thuya, etc., enjoyed some favour, and gave temporary relief, but Prof. Robin recommends bihydrochlorate of quinine in 10-grain doses twice a day, and cacodylate of soda, while the cachectic condition might be treated with injections of glycero-phosphate of lime, 5 grains daily for 25 to 30 days.

Chelidonium, or its alkaloid, chelidonin, has been much recommended by Deiussenko, Ivanov, Kraisky, Meyer, Robinson and others. In cases of ulcer of the stomach, carcinoma, cancer of the intestine, the results obtained would seem to have been favourable and rapid; under its influence the tumour diminished, and a general improvement took place. It acts as an hypnotic, and moderates the development of the neoplasm. Chelodonin is given in pills of 2 milligrammes in progressive doses (3 to 12 daily), according to tolerance.

Although there is no curative treatment for cancer of the stomach, there is a medical treatment sufficient to prolong life, relieve suffering, and give hope to the patients. Gastro-enterostomy should be reserved when it is impossible to otherwise relieve the pain of certain cancers.

Treatment of Vomiting.

Hydrochlorate of cocain,
Hydrochlorate of morphia, } ā ā ½ gr.
Lime water, 6 oz.
A tablespoonful every hour.

Or,

Hydrochlorate of cocain, 1 gr.
Antipyrin, 30 gr.
Syrup of oranges, 6 oz.

Or,

Tincture of iodine, 1 dr.
Chloroform, 1 dr.
5 drops every half-hour up to 19 drops (pregnancy).

Or,

Tincture of iodine, 30 m.m.
Spirits of chloroform, 2 dr.
Water, 4 oz.
A tablespoonful every hour.

GERMANY.

Berlin, Oct. 20th, 1907.

At the meeting of the Society for Public Health, the subject of

Epidemic Cerebrospinal Meningitis

came up for discussion. Statistics were brought forward by Professor Flügge, who also answered the question as to how infection took place. There was no longer any doubt that the disease was caused by Weichselbaum's meningococcus. The apparently healthy were the dangerous ones. The disposition to contract the disease was mostly amongst children, and especially those with enlarged tonsils. It was the coccus carriers, who felt well and not those who were ill, that were the disseminators of the disease. The principal danger was for those in the immediate neighbourhood of the centres of infection.

It was certain that the disease was introduced into localities previously free by healthy persons coming from an infected district. Isolation was certainly necessary but not indispensably so. Disinfection did but little service. All those around a case of the disease should be looked upon as carriers of it. It was necessary that instructions should be given that intercourse with those in the neighbourhood of the disease should be carried on as cautiously as possible; that those who were healthy should receive warning in regard to those coming from infected houses for at least three weeks; that children from such houses should be kept away from school for several weeks, etc. The carriers of the bacilli should be looked after daily by the medical officers. The serums prepared by Merck and also that of Kolle, of Bern, were of value both for diagnostic and therapeutic purposes.

Hr. Bruhns, Gelsenkirchen, agreed with what had been said. The society for combating folk-diseases should erect small sanatoria in many localities, where the bacillus bearers could be examined at once.

Professor Erismann, Zürich, would isolate all the bacillus bearers, regardless of all other considerations, but would compensate them for loss of work. Hr. Czaplewsky, Cöln, drew attention to the special danger of kissing.

Geh. Obermed.—Rat Kirchner, Berlin, said there was not money enough to separate all the bacillus bearers, and there was no possibility of shutting up more than half the population. Those infected must be isolated under any circumstances. Wherever the disease appeared the State should at once send bacteriological experts, cover the country with a network of bacteriological institutions, and steadily draw the net closer. The different parishes must disinfect free of cost.

Hr. Deneke, Hamburgh, thought the time would come when an outbreak would be foretold, and the population receive timely warning.

Stabsarzt Dr. Kutscher, Berlin, thought that as the cocci did not grow outside the body there must be permanent bacillus bearers. The bacilli frequently disappeared for a time, to return again later on. In the Institute for Infective Diseases two kinds of serum were prepared and distributed gratuitously, one in the form of snuffing powder for bearers of germs, and the other for those who were ill of the disease. The serum was only active during the first three days, and must be used quite fresh.

Dr. Peerenboom, Wilhelmshafen, proposed that when an epidemic threatened all the lymphatic children who were likely to take the disease should be removed to convalescent homes in time, and detained there.

The Influence of Mineral Waters on the Digestive Tract.

The *Deutsche Med. Zeitung*, No. 76, has a reference to a paper on this subject by Dr. Pewsner. In it the writer claims that experiments on animals have shown that the mechanism of gastric secretion is identical in all particulars in the human subject and in dogs. Experiments, therefore, that have been carried out with regard to the action of mineral waters on animals with gastric fistulæ must have a certain value clinically. Mineral waters that contain carbonic acid (Seltzer and Ems) increase the gastric secretion very much. Simple service drinking water increases it moderately, Carlsbad water diminishes it, purely alkaline mineral water (Vichy) and bitter waters (Hunyadi-Janos, Friedrichshall) diminish it very much. The amount of pancreatic secretion does not run parallel with the quantity of water taken. As regards the digestive power on albumen and starch, the gastric juice secreted after taking Vichy water takes the first place. The juice secreted after taking ordinary drinking water takes the last place of all. He thinks that the importance of mineral waters in the treatment of disorders of the digestive tract should not be overestimated. Where mineral waters are made use of it is above all important that the diet should be in every way suitable.

AUSTRIA.

Vienna, Oct. 20th, 1907.

Tuberculosis.

The conference on tuberculosis has finished its deliberations for another year, without marking any epochal event. The disease is still cutting off 2.5 per thousand, or a 1-7th of those who die are tubercular according to the official reports, which would stand at a higher figure were it not limited by insurance pressure.

The Vice-President, Prof. Schrötter, greeted the members in the Grand Festesaale of the University. States, corporations, and private bodies were represented by deputies. In his remarks Schrötter hoped that this fiend would soon be arrested in its destruction, but feared it would not be overcome till the people practised hygienic principles and drove it from their midst by their own efforts.

Bienerth, Austrian Minister for the Sanitary Department, described many of the methods and institutions they had erected in Austria to reduce the number of victims dying from this disease, and praised Schrötter for his rational and scientific assistance he had given to his own department. He had still hope that these humane institutions would lead Austria to improve her hygiene and social politics.

The first paper was read by Prof. Weichselbaum on the method of infection. He reviewed the earlier notions, and said our present knowledge was still imperfect, and the method of infection attributed to two channels, inhalation and alimentation, these being supported by Calmette and Flügge.

Calmette holds that tubercle is conveyed to the system through the alimentary tract, particularly the bowel, and that dust or moisture had no share in the communication. On the other hand Flügge is as firmly convinced that his "drop" theory of the infection passing in by the lungs is the correct one.

He believes it is conveyed by the mouth in dust or moisture, and trickles down the trachea to the lung or finer bronchi. Calmette founds his opinion on animal experiments, while Flügge draws his from cases entering his own institution. Between these extremes other authors form a grand mean of the infection being taken in by both channels. Weichselbaum recorded many of his own experiments performed before the discovery of the tubercular bacillus in feeding dogs with sputum, which convinced him at the time that tubercle was not so easily taken in by the animal species by the alimentary canal as through the lung. Since that time he has somewhat modified his opinions. In the pulmonary and bronchial glands the bacilli are fewer than in the cervical and glands of the mesentery. In the latter the process is more rapid and intense in development. The earlier theories were that the pulmonary and bronchial glands were physiologically reduced, and in the older experiment with animals the anthracosis was attributed to this cause, while in the later experiments the low development in the lymphatic tissues was reduced below that of the neck and mesentery. This explanation accords with the earlier examination of the lymphocytes, which are supposed to have played an important part in fighting the tubercular bacilli; it therefore resolved itself into an imperfectly developed lymph system as opposed to the formation of lymphocytes. Notwithstanding the alimentary theory Weichselbaum is convinced that the air and the lungs still play an important part in the connection of the bacilli through the bronchial glands.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Professor Chiene's Reminiscences.—Professor Chiene opened the class of Systematic Surgery on the 16th by a retrospect of his work as a teacher. "Forty years ago," he said, "John Goodsir sent for me to his house at Wardie. I found him lying in a narrow, camp-like bed, in a narrow room, a small table at his side, and on the table Quain's 'Anatomy' and his Bible. He asked me how the students were getting on, and bade me farewell. His last words were, 'Teach the students, Dr. Chiene,' and I have taken these words as my life motto. To-day, when I celebrate my silver wedding—twenty-five years a professor—I take as my subject 'Looking Backward.'" Professor Chiene then gave a sketch of his career since graduating in 1865, and recalled how, at three o'clock one afternoon, Professor Turner asked him to give the four o'clock demonstration in anatomy. He felt a little nervous, and went into the lecture theatre, but forgot to turn up the gas on the body, and delivered the demonstration. The students were kindly fellows; they never by word or look pointed out the omission, and he only discovered it next day. From the anatomy theatre Professor Chiene took his audience to the old building on Nicholas Square, where he at one time had his systematic class. The turning-point, however, in his surgical career came in the spring of 1866, when he was introduced to Joseph Lister. From the day Lister came to Edinburgh in 1866 until he went to King's College in 1878, Professor Chiene spent daily two hours in his wards, and watched Lister at his daily work elaborating with zeal, and patience, and doggedness the imperishable system which he had been privileged to see an accomplished fact. The comparison of work in the Edinburgh Royal Infirmary in the early 'eighties and now was of interest, remarked Professor Chiene. In the first period 752 operations were performed—107.3 per annum; 24 years later 2,803 operations, or 400.5 per annum. Taking the general mortality over the two periods, the percentage of deaths was 7.2 between 1878 and 1885; 6.7 between 1899-1905. In 1882 he started the first teaching bacteriological laboratory in the United Kingdom, and when the new regulation became law in 1902 the teaching of bacteriology passed into the hands of the Professor of Pathology. After some further reminiscences of the nurses who had worked under him, and of his early personal friendships, Professor Chiene went on to say that it was the kindly, gentle people who were remembered, while the pushers—rhinocerous-hided or serpentine in their ways—were soon forgotten. He urged the students to read their Bible; he sometimes thought it would be a good thing if the Bible formed one of the subjects for the medical preliminary examination. A man who knew his Bible well was on the way of becoming a good surgeon.

Larbert Asylum.—In the evolution of asylums into "hospitals" for the insane, the female nurse has been a very important factor, and has done much to revolutionise the internal economy of such institutions. In accordance with these facts, a handsome new nurses' home has just been completed in the Stirling District Asylum, and will provide accommodation for 85 nurses. Special features have been made of the library and lecture-room, so as to enable nurses to study and get special training in mental nursing. So successful has the female nurse proved in the management of the insane, that asylum directors are now anxious to attract the best class of women. The whole atmosphere of asylums has been changed in consequence of the advent of female nurses. Excited male patients, it is found, who would fight with one of their own sex, never dream of striking a woman. As an example of the progress which has been made at the Stirling Asylum, Dr. Robertson states that for many years not a patient has been locked up in a single room in the institution either by day or night. Padded rooms have become store-rooms, and the strait-waistcoat is obsolete. The new home will shortly be formally opened by Lord Balfour of Burleigh. It has cost the directors £10,000.

Fatal Attack on an Asylum Attendant.—Daviot Asylum, a branch of the Aberdeen Royal Asylum, where harmless patients who can do agricultural work are located, was last week the scene of an unfortunate tragedy. A number of patients were engaged, under the supervision of attendants, in cutting thistles in a field. While they were returning from work, one of them was seized with a sudden impulse, and, without the slightest warning turned on one of the attendants and inflicted on him with a scythe a frightful wound in the throat, which was almost immediately fatal. The patient who committed the deed had never shown any sign of homicidal tendencies, and was of a quiet and inoffensive disposition.

BELFAST.

Derry County Infirmary.—An interesting discussion took place at the monthly meeting of the County Infirmary at Derry last week, when the resident surgeon, Dr. J. G. Cooke, made an application to be allowed to take consulting practice outside the county as well as in it. He promised to provide an efficient substitute during the time he might be absent from the infirmary. A good deal of objection was raised to the application on the ground that it would be in surgical cases that Dr. Cooke would most likely be consulted and that he would have to operate, and be absent for rather long times. The Chairman of the Board wanted to make it a condition that Dr. Cooke should pay a junior house surgeon £50 a year to spend his whole time in the infirmary, and be subject to their regulations. It was not clear whether by an efficient substitute Dr. Cooke meant some one to keep an eye on the place in his absence, or some one actually to sleep in the infirmary if he were absent for a night; some members of the Board thought that the latter should be the understanding. Eventually the original proposal was accepted, and leave granted to Dr. Cooke as asked, without special restrictions.

Royal Victoria Hospital.—The winter session opened at the Royal Victoria Hospital on Thursday, 17th, with an address by Dr. R. J. Johnston, assistant gynæcologist. In the absence of Dr. J. Walton Browne, the chair was taken by Sir William Whitla, the senior member of the staff present. Dr. Johnston gave an interesting and humorous address on the general education of the medical student, dwelling specially on the necessity for training the mind in right methods of thinking. On the motion of Sir John Byers, seconded by Professor Symington, a hearty vote of thanks was passed and conveyed to Dr. Johnston.

LETTERS TO THE EDITOR.

THE PROFESSION AND THE PUBLIC.

To the Editor of The Medical Press and Circular.

Sir,—Some of the chief items in the current issue of your admirable journal form painful reading for those who love their profession and appreciate the fine spirit that pervades the majority of its members. There is first the quotation from the Socialist children's catechism. The malignant feeling there displayed is very largely the direct product of the teaching of rabid anti-vivisectionist and anti-vaccinationist fanaticism. The former constantly holds up the profession to execration, if not as practisers of fiendish cruelty, as admirers of men who devote their lives to deliberate infliction of suffering upon helpless brutes, well knowing that useful results are more than doubtful. The teaching of Mr. Stephen Coleridge among laymen, and of Archdeacon Wilberforce, chaplain to the Speaker, among the clergy, may be cited in this connection. Your editorial note headed "Vivisection Horror" exemplifies once more the methods of fanaticism. Then the anti-vaccinationist's favourite statement is to the effect that for the sake of the paltry fees which the duty brings, the whole profession is engaged in a vile conspiracy—they even vaccinate their own children to supply colour to their hypocrisy—to disseminate a loathsome poison throughout the population. These teachings prepare a fruitful soil for the operations of fraudulent quackery, which, again, is dealt with in another of your pages. The cynical and cruel rogues who find fortune in one or other of the lines of quackery gain ready victims among simple, innocent, and suffering, and therefore confiding, people, wrought upon by the enemies of scientific medicine. Every practitioner of experience must encounter numbers of wretched patients who have left their diseases to pass into hopeless phases whilst relying upon the promises of ignorant knavery. The amount of easily preventible human suffering and misery which is being indirectly caused in this country alone by the teachings of "anti" fanatics outweighs ten thousand times the pain inflicted upon the lower animals in all the physiological laboratories throughout the entire world. In the meantime, the profession remain passive, if not apathetic, in presence of systematic libel and vilification, and make no effort even to demand or force from the State the dues justly owing to them in return for the obligations they are obliged to fulfil in obtaining what remains so far a really worthless status.

I am, Sir, yours truly,
Physiologist.

October 18th, 1907.

THE GOVERNMENT'S SCHEME FOR THE PROMOTION OF UNQUALIFIED MEDICAL PRACTICE.

To the Editor of The Medical Press and Circular.

Sir,—Dr. Moore, of Huddersfield, claims to be the true begetter of the "Notification of Births Bill" (Medical Press, October 10th), and I will not question its genesis; but I will beg of Dr. Moore to remember that we are members of a profession which claims to be free and enlightened. In our search for truth we must occasionally criticise the views of each other, and Dr. Moore must not complain if we exercise our privilege to comment on the possible effects of his Bill.

I am prepared to believe that Dr. Moore, with the aid of his two very efficient lady doctors, can have the Notification of Births Act carried out without encouraging unqualified practice; but I am firmly convinced that unqualified practice must result from its adoption in most big cities.

It is a presumption of law that a man must be held to intend the natural and proximate effects of his act, and I insist that the natural and probable effects of an Act which thrusts an unqualified nurse on a family the moment a child is born, to direct its rearing, must result in the establishment and encouragement of these unqualified persons, to the detriment of the medical practitioner and the infringement of his rights.

Regarding the discussion of the Bill generally, I think that I must complain of Dr. Moore. The views put forward in my paper which appeared in The Medical Press were given, in effect, in some comments which I made on the communication of Dr. Moore to the Douglas Public Health Congress. I may be right, or I may be wrong, but I claim the right to discuss such papers freely, for unless both sides of a question be debated, it is impossible to arrive at the truth. The Douglas newspapers made a sensational paragraph out of my observations, which I never saw or took notice of, but some of my political opponents in the Dublin Corporation wrote to Dr. Moore inquiring if the paragraph in question represented what I had said. Obviously, a sentence or two, detached from its context, is very likely to convey an erroneous impression; but, in spite of my denials, and the statements of the gentleman who presided at the section, Dr. Moore's communication to the gentlemen in question seems to have inspired them with the belief that I advocate the callous neglect of delicate infants, if not their wholesale murder.

Subject to your ruling, Mr. Editor, I submit that if a number of doctors are discussing a scientific subject in a scientific way, each should be at liberty to express himself freely; that if a lay paper, for the sake of making sensational statements, suggests that one of the speakers advocated something like child murder, and the doctor in question repudiates the insinuation, and the president of the section likewise, his colleagues should not answer his political opponents behind his back to the effect that his repudiation was not to be believed, and so encourage them to have the repudiated report placarded on the walls of the City Hall of his native town.

This is what has happened to me. The views which I expressed at Douglas or in your journal I am ready to defend, as to their truth and their wisdom, in any medical journal, or before any body of my colleagues. It does not follow that I should be called on to defend them in the Dublin Corporation or amongst my patients. It was not a lay sermon to the laity, but a scientific discussion before a scientific audience.

There must be an end of free discussion amongst medical men if one of them is at liberty to convey to lay outsiders a garbled account of the statements of another. Thus, I happen to be a Fellow of the Royal Society of Medicine. If I should chance to take part in a discussion on any subject, if my opinions are not those usually held, and if some lay paper makes a paragraph imputing views to me which I repudiate, is the person whose paper is criticised to communicate with my adversaries in the Corporation of which I happen to be a member, and give them an opportunity of perhaps blasting my career for ever?

I suggest that the unwritten law of the profession requires that when medical men have a scientific discussion, and when views are imputed to one of the participants which he denies, and which are calculated to do him harm, it is the duty of his medical colleagues to accept the denial, and not to communicate with outsiders who wish to impeach him on the question.

I am, Sir, yours truly,
J. C. McWalter.

October 10, 1907.

CASE OF THE LATE DR. J. P. MAGUIRE.

To the Editor of The Medical Press and Circular.

Sir,—On behalf of the widow of the late Dr. J. P. Maguire, I thank you for the assistance you have given by publishing my appeal in your columns. Appended hereto is a list of names of those who have generously subscribed, and who now have the satisfaction of knowing that their charitable and kindly action has rescued this deserving case from penury, enabled her to pay the expenses of training as a midwifery nurse, and so earn her living in the future.

I intend to close the list on the 9th prox., and as the widow has many expenses to meet I hope to receive some more subscriptions before the list is closed.

I am, Sir, yours truly,
R. B. Mahon.

Ballinrobe, co. Mayo,
18th October, 1907.

	£	s.	d.
AMOUNT ALREADY ACKNOWLEDGED ...	...£28	9	0
Dr. Hession. Tuam ...	£1	0	0
Dr. T. McCarthy, Sherborne	1	1	0
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	£57	15	0
Disbursed to date	6	0	0
Balance in hand	£51	15	0

SPECIAL ARTICLES.

THE DUBLIN HOSPITALS.

As our readers are aware, certain of the Dublin Hospitals, nine in number, viz., the Westmorland Lock, Dr. Steevens', the Meath, Cork Street Fever, the House of Industry, the Rotunda Lying-In, the Coombe Lying-In, the Royal Victoria Eye and Ear, and the Royal Hospital for Incurables, are in receipt of direct grants from Parliament. These grants vary in amount from £100 to the Royal Victoria Eye and Ear Hospital to £7,563 to the House of Industry Hospitals. In order to exert a general supervision over the management of these hospitals, a Board of Superintendence is in existence, which inspects them and presents an annual report to the Lord Lieutenant. The signatories to the present Report (*a*) are twelve in number, together with the Secretary. The Secretary and four of the members of the Board are medical men. The Report, as we have been accustomed to it for many years, consists of three parts:—(1) General comments on the hospitals as a group; (2) brief reports on the condition of each hospital; (3) series of tables giving information regarding each hospital as to the diseases treated, the sources of income and the channels of expenditure, the dietaries, the cost of provisions, and other such matters.

These tables, if trustworthy, are of value to all interested in hospital management, and the comparison afforded should be particularly useful to the authorities of the hospitals under review. On glancing at the tables some curious contrasts are noticed. Thus, comparing the three general hospitals as regards the average annual cost per bed for maintenance, we find that in Steevens' and the Meath the cost is £23 5s. 7d. and £21 5s. 3¾d. respectively, while in the House of Industry it is only £14 18s. 3½d. Again, comparing the two lying-in hospitals, we find that the Rotunda, with an average of 88 beds occupied, spends £6 1s. 2d. on stimulants, whereas the Coombe, with less than half the number of beds (38) spends more than twice that sum (£15 4s. 1d.). We have called attention to this contrast in previous years. Again, the drug bill at the Coombe is some twenty pounds greater than that at the larger institution; while, stranger still, the drug bill at the Royal Victoria Eye and Ear Hospital is the largest of any, though it has only an average of 71 beds occupied, against 158 at the House of Industry.

Certain of the tables, however, are hardly intelligible as they stand. Thus, from Table No. 5, p. 29, which purports to show, among other things, "the present extent of accommodation for each class of patients," it would appear that there are no beds for lying-in patients, incurable patients, or ophthalmic patients, although four of the hospitals in the list are devoted specially to these classes. Presumably, the returns have not been made, but if so, this should be stated. It is, however, on comparing the mortality as given in this table with that as given in Table No. 1, pp. 10-24, that we find the most astonishing discrepancies. The figures for the hospitals, regarding which information is given in both tables, are as follows:—

	Table I.	Table V.
Westmorland Lock	0 ..	5
Steevens'	52 ...	52
Meath	79 ...	78
Cork Street	193 ...	200
Hardwicke	63 ..	46
Whitworth	64 ...	43
Richmond	36 ...	64
Coombe "Chronic Wards" ...	0 ...	1
Royal Hospital for Incurables ...	40 ...	40

It will be seen that only in two cases do the figures tally.

Turning from the tables to the body of the Report, we find that the Board saw everything, and, behold, it was very good. Praise is lavished on everyone concerned in hospital management, and on every detail of the hospitals inspected. Nowhere is to be found—we do not say the slightest censure—but the slightest suggestion for improvement. We are quite in accord with the Board in believing that the Dublin hospitals are, on the whole, well and economically managed, and in urging that more money is sadly needed, but we can hardly regard them as perfect. As an example we may refer to the case of one hospital, on whose management we have had before now to comment adversely. The Report says:—

> "The Lock Hospital.
>
> "On inspection we found the wards and other parts of this institution thoroughly clean, well ventilated, and in excellent sanitary condition. The bedding and bed-clothes were in good condition, the floors were well scrubbed, regularity prevailed in every department, and the whole management impressed us as highly commendable. Each patient was questioned as to whether her comfort and well-being were satisfactorily attended to, and the answers without exception were in the affirmative. In the basement we were struck by the cleanliness of every corner—a condition difficult to bring about and maintain in a very old building. The method of cooking is good, and the different descriptions of food were all that they should be."

In 1903, we commented (Medical Press and Circular, July 8th, 1903) on the strained relations which existed at the time between the Lady Superintendent and the nursing staff, owing to which three of the four staff nurses resigned. We understand that these relations have not improved since that time, and that whereas at the date of the recent inspection by the Board of Superintendence there were three staff nurses in the hospital, there is now only one. Moreover, this remaining nurse is the maternity nurse, who should not be supposed to concern herself with other than maternity duties. From the Report it would not appear as if there were any maternity cases in the hospital, whereas we understand that there is an average of some five-and-twenty in the year. We conceive that it is the duty of the Board of Superintendence to inquire into and comment on such matters as these. It is not through ignorance of them, however, that the Board has kept silence. The affairs of the hospital were brought before the Board by one of its members, who expressed strong dissent from the paragraph we have quoted. In spite of his dissent, his signature is attached to the Report, though we understand he has since sent his resignation to the Lord-Lieutenant as a protest against such treatment.

The Board of Superintendence has a serious duty to perform to the hospitals of Dublin and the public.

(*a*) "Forty-Ninth Annual Report of the Board of Superintendence of the Dublin Hospitals, with Appendices, for the Year 1906-1907." Dublin: H.M. Stationery Office. 1907.

It is its duty to bring an intelligent and independent criticism to bear on the management of these institutions. Strictures should be made where required, and suggestions freely offered. There is doubtless much to praise, but there is also something to amend. It was hoped by many that the recent change of secretaryship, consequent on the lamented death of Dr. Martin, would have resulted in some infusion of freshness into the Report. This hope has been disappointed, for the present Report is, as we have said, pitched in a high strain of eulogium from start to finish. Moreover, as we have shown, the statistics are not to be implicitly trusted. The editing is careless in the extreme, the proofs having apparently been left uncorrected. Within one table of some thirty names (p. 21) we find the following misprints: Hyda-hidiform mole, Lacerated Permaimus, Hydrammos, Galachacele, urticarie, Pyamia.

MEDICAL NEWS IN BRIEF.

The Tuberculosis Exhibition in Dublin.

During the past week the Tuberculosis Exhibition in Dublin attracted large numbers of visitors of every class, particularly of members of local sanitary authorities, who took notice of the means adopted in various English and other cities to combat tuberculosis. Each day, either in the afternoon or the evening, a popular lecture was delivered by a medical or other expert qualified to speak with authority, her Excellency the Countess of Aberdeen occupying the chair at most of the lectures. On Monday evening the Registrar-General (Mr. Matheson) lectured on "Tuberculosis in Ireland." He contrasted the statistical history of tuberculosis in England, Ireland, and Scotland from the years 1864 to 1906. While in 1864 Ireland stood lowest of the three, with a rate of 2.4 per 1,000 living, the rate for England being 3.3, and that for Scotland 3.6, in 1905 Ireland occupied the unhappy position of being the highest, with a rate of 2.7, Scotland being next with 2.1, and England lowest with a rate of 1.6.

The lecturer told his audience that out of a total of 74,247 deaths registered in Ireland in 1906, no fewer than 11,756, or 15.8 per cent., were due to the disease. Amongst the classes which were well housed, clothed, and fed, the mortality from the disease was much less than among those who had not those advantages. He instanced insanitary houses and surroundings, intemperance, and neglect of precautions against infection as the main causes favouring the spread of the disease, and emphasised the necessity of the establishment of special dispensaries, sanatoria, and hospitals in order to check its growth.

Dr. Lawson, Medical Superintendent of Nordrach-on-Dee Sanatorium, chose as the title of his lecture "Some Aspects of the Tuberculosis Problem." It was illustrated by a number of limelight views. He advocated, among the measures to be adopted in coping with the evil, the provision of improved dwellings for the workers in the towns; the adoption of regulations which would render it an offence, involving a legal penalty, to expectorate in public; the inspection of the milk supply with a view to securing its purity; the compulsory notification of pulmonary tuberculosis; and the erection of two classes of buildings for the accommodation of consumptive patients—one class designed for advanced cases, where the patients might be cared for until they died, and another class to which others might go with a reasonable prospect of recovery.

Dr. McSweeney lectured on "The Campaign Against Tuberculosis in Germany," giving a résumé of the facts detailed in his well-known Report to the Local Government Board.

Mr. Lentaigne lectured on "Tuberculosis of Bones and Joints." It was most difficult, he said, to get such cases retained in general hospitals as long as they should be, and consequently real and permanent cures were far less frequent than they should be. He thought it would be well that when sanatoria were being constructed accommodation should be provided for such cases to complete their cure after a short stay in a general hospital for special surgical treatment. They might be accommodated with the pulmonary cases, but it would be better and safer when cheap wooden buildings and sheds were being erected for the purpose to have special buildings of a similar character, but with special trained nurses and some special surgical equipment for these cases. Tuberculosis was produced in three ways—by inhalation with the breath, by swallowing with food, and by inoculation. Tuberculosis by inhalation could be prevented from spreading by segregation and by the education of the public. They could prevent the infection through the medium of food by the same means, and by putting an end to the sale of infected milk. That could be done if it was made a penal offence for anyone to sell milk from animals that had not been certified free from tuberculosis. The disease would them be very soon stamped out in domestic cattle. The campaign should be one of education and agitation. They had to combat three enemies—economy, ignorance, and apathy. In order to overcome the enemy of ignorance he strongly advocated, among other measures, the imparting to children a proper health training. They should agitate for notification for suitable hospital accommodation, and for the restriction of the sale of poisonous milk.

The attendance at all the lectures was gratifying, and an interesting discussion followed each lecture.

Prosecution by the Dental Association.

At the Worcester Police Court, on October 14th, Percy Smith, Beacon View, Woolhope Road, was summoned by the British Dental Association for unlawfully using a certain description implying that he was a person specially qualified to practise dentistry. Mr. Maund appeared for defendant, who pleaded not guilty.

Counsel said the case was taken under the Dentists Act, 1878, which said a person should not be entitled to take the name of dentist or dental practitioner, implying that he was specially qualified, unless he were registered under the Act. Defendant had been employed by Mr. F. W. Sievers, a Worcester dentist, first as house-boy and then as mechanic. He had at no time during that period had experience in dental operations. He was discharged by Mr. Sievers, and soon afterwards mentioned that he had started on his own account, and handed to Mr. Sievers' cook a card, which was the cause of the prosecution. The card was as follows:—"Artificial teeth: high-class work at moderate charges; painless extractions; advice free. Mr. Percy Smith. Beacon View, Woolhope Road, Worcester. Seventeen years with Mr. F. W. Sievers, L.D.S." The Dental Association maintained the card was an infringement of the Act the object of which was to prevent unqualified persons from practising dentistry. The man implied by the card that he had had experience. Mr. Sievers said defendant was employed by him for seventeen years. He was never allowed to operate, and witness would not be allowed to employ an unqualified assistant. Mr. Maund said defendant was doing nothing that he thought was legally or morally wrong in adopting the means of advertisement others used. He had now withdrawn the card. Mr. Maund argued that the card did not necessarily imply that defendant was a registered practitioner.

Defendant was fined £2 and costs.

Royal College of Surgeons in Ireland.

The Winter Session commenced on Tuesday, October 15th, when the prizes of the previous Session were distributed by the President of the College as follows:—Barker Anatomical Prize—£31 10s., G. S. Levis. Carmichael Scholarship—£15, J. Menton. Gold Medals in Operative Surgery—P. G. M. Elvery and T. Sheehy (equal). Stoney Memorial Gold Medal in Anatomy—Miss I. M. Clarke and G. C. Sneyd (equal). Descriptive Anatomy—Junior—J. T. Duncan, 1st prize (£2) and medal; T. Dowzer, 2nd prize (£1) and certificate. Senior—H. G. P. Armitage, 1st prize (£2) and medal; W. Swan, 2nd prize (£1) and certificate. Practical Anatomy—First Year—T. M. Thomson, 1st prize (£2) and medal; F. W. Warren, 2nd prize (£1) and certificate. Second Year—W. Swan, 1st prize (£2) and medal; H. G. P. Armitage, 2nd prize (£1) and certificate. Practice of Medicine—C. Greer, 1st prize (£2) and medal; G. S. Levis, 2nd prize (£1) and certificate. Surgery—G. S. Levis, 1st prize (£2) and medal; W. R. Burton, 2nd prize (£1) and certificate. Midwifery—H. W. White, 1st prize (£2) and medal; G. S. Levis, 2nd prize (£1) and certificate. Physiology—H. M. E. H. M'Adoo, 1st prize (£2) and medal; O. G. Connell, 2nd prize (£1) and certificate. Chemistry—P. V. Crowe, 1st prize (£2) and medal; J. T. Duncan, 2nd prize (£1) and certificate. Pathology—I. Scher, 1st prize (£2) and medal; C. Greer, 2nd prize (£1) and certificate. Physics—J. T. Duncan, 1st prize (£2) and medal; T. Buckley, 2nd prize (£1) and certificate. Practical Histology—F. W. Warren, 1st prize (£2) and medal; J. S. Pegum, 2nd prize (£1) and certificate. Practical Chemistry—H. C. Gilmore and J. Kirker (equal), 1st prize (£2) and medal. Public Health and Forensic Medicine—H. Hunt, 1st prize (£2) and medal; Miss C. F. Williamson, 2nd prize (£1) and certificate. Materia Medica—J. Menton, 1st prize (£2) and medal; Miss C. F. Williamson, 2nd prize (£1) and certificate. Biology—J. T. Duncan, 1st prize (£2) and medal; P. V. Crowe, 2nd prize (£1) and certificate.

The Royal College of Physicians of Ireland.

The annual meeting of this College was held on St. Luke's Day. The President, Censors, Examiners, and other officers for the ensuing year were elected as follows:—

President—Dr. Joseph M. Redmond. Censors—Drs. Norman, Murphy, Jellett, and R. Travers Smith. Vice-President—Dr. Norman.

Additional Examiners to take the place of an absent Censor:—Medicine—Dr. Matson. Medical Jurisprudence and Hygiene—Dr. Montgomery. Midwifery—Dr. Glenn. Examiners in Midwifery—Dr. Horne, Dr. Wilson. Examiners, in addition to Censors, under the Conjoint Scheme: — Biology — Dr. Kirkpatrick. Chemistry—Dr. Lapper, Dr. Falkiner. Physics—Dr. Peacocke, Dr. Winter. Pharmacy, Materia Medica, and Therapeutics—Dr. Drury, Dr. Dempsey. Physiology—Dr. Earl. Pathology—Dr. F. C. Purser. Medicine—Dr. Parsons, Dr. W. J. Thompson. Hygiene and Forensic Medicine—Dr. Dawson. College Examiners for the Conjoint Preliminary Examination:—Mr. E. H. Alton, F.T.C.D., Mr. R. A. P. Rogers, F.T.C.D., Dr. Connor Maguire. Examiners for the Conjoint Diploma in Public Health:—Hygiene—Dr. Bewley. Chemistry—Dr. Lapper. Meteorology—Dr. Winter. Examiners for the Membership:—Clinical Medicine—Dr Wallace Beatty, Dr. Murphy. Practice of Medicine—Dr. O'Carroll, Dr. R. Travers Smith. Pathology.—Dr. Earl, Dr. O'Sullivan.

Dr. James Spencer Sheill, M.R.C.P. and L.R.C.S.I., was elected a Fellow of the College.

The annual dinner of the College was held on Saturday, the 19th inst., in the College Hall, and was largely attended. Amongst the guests were Lord Justice Holmes, the Master of the Rolls, the Provost of Trinity College, the President of the Royal College of Surgeons, the President of the Royal Irish Academy, the President of the Royal Irish Academy of Medicine, his Honour Judge Craig, Sir Charles Ball, Mr. Harrington, M.P., Sergeant O'Connor. The toasts consisted of "The King," "The Guests," "The Sister College," "The President," "The Registrar."

Haslar Hospital.

The course of instruction at Haslar Hospital for the naval surgeons who entered at the spring competitive examination has just come to an end, and the usual awards have been made to the three surgeons who have so far most distinguished themselves. Surgeon R. Connell, M.B. (Trinity College, Dublin), has gained the gold medal, and Surgeon C. Ross (Glasgow University) the silver medal, whilst the third award, in the form of a handsome microscope, has been made to Surgeon G. Price, a former student of St. Thomas's Hospital.

The Medical Exhibition.

In our report and description last week of exhibits at the Medical Exhibition held in London, we referred to the recently introduced preparation "Miol" as an emulsion of cod liver oil and malt. This was a slight slip of the pen for olive oil and malt, a decidedly useful therapeutic novelty, one which doubtless will be duly appreciated by the profession when better known.

PASS LISTS.

Conjoint Examinations in Ireland by the Royal College of Physicians and Surgeons.

The following candidates have passed the first Professional Examination, October, 1907:—

M. L. Bourke, F. E. Fitzmaurice, J. M. Gilmore, C. H. Joynt, J. Kirker, C. J. Kelly, A. G. J. MacIlwaine, B. Malaher, B. Murphy, D. McDevit, B. Neary, A. J. Neilan, M. K. O'Byrne, J. H. Rishworth, C. Roche, G. Wilson, and G. Young.

The following candidates have passed the Preliminary Examination:—

J. T. McConkey (with honours), J. I. Pollock (with honours), W. I. Adams, A. C. J. Austin, A. J. Bodell, G. Bailey, A. T. Cannon, G. Campbell, T. F. Collins, D. Dudley, A. P. Flood, P. A. Gardner, R. M. Gordon, S. Griffin, D. J. Healy, N. S. Hood, T. Kennedy, W. J. Marmion, M. Meehan, D. Murphy, J. J. Murphy, A. J. Patterson, F. P. Shields, M. Scher.

Copies of the Preliminary Regulations for 1908 can now be obtained on application.

The Royal University of Ireland.—Medical Degrees Examinations.

The following candidates have passed the undermentioned examinations:—

The M.D. Degree Examination.—Thomas Barry, M.B., B.Ch., B.A.O.; Robert Chambers, M.B., M.B.B.Ch., B.A.O.; Foster Coates, B.A., M.B., B.Ch., B.A.O.; William J. Maguire, B.A., M.B., B.Ch., B.A.O.; James B. Slattery, M.B., B.Ch., B.A.O.; Robert Steen, M.B., B.Ch., B.A.O.; William J. Wilson, B.A., M.B., B.Ch., B.A.O.

The M.B., B.Ch., B.A.O. Degrees Examination.—Upper Pass.—Thomas S. S. Holmes, James B. Lapsley, John E. A. Lynham, B.A., William D. O'Kelly, Herbert H. Prentiss, James Shaw, James A. Shorten, B.A., Alexander L. Stevenson.

Pass.—Joseph H. P. Boyd-Barrett, Edwin B. Brooke, Matthew F. Caldwell, Gault Calwell, William F. A. Carson, Robert Cox, B.A., James Dewar, Michael F. Donovan, B.A., James J. Flood, Charles E. L. Harding, John J. Hickey, James Horgan, James B. Horgan, John Hughes, Francis Keane, Joseph P. Kerlin, Richard R. Kirwan, Thomas J. McAllen, John S. McCombe, Wiclif McCready, Augustine P. MacMahon, John J. O'Reilly, Christopher F. X. O'Sullivan, Daniel T. Sheehan, James Sinclair, Hans C. Swertz.

The following candidates are exempted from further examination in the subjects set after their names:—Robert G. Kevin, the Medicine Group; John F. Neary, the Medicine and Midwifery Groups.

The following candidates may present themselves for the further examination for Honours in the groups mentioned after their names:—James B. Lapsley, the Medicine Group; William D. O'Kelly, the Midwifery Group; Herbert H. Prentiss, the Medicine, Surgery and Midwifery Groups; Daniel T. Sheehan, the Midwifery Group; James A. Shorten, B.A., the Medicine and Surgery Groups; Alexander L. Stevenson, the Medicine and Surgery Groups.

Royal College of Surgeons of Edinburgh.

At the annual meeting, held on 16th inst., Mr. Joseph Montagu Cotterill was unanimously elected President for the ensuing year. At the same meeting the following gentlemen, having passed the requisite examinations, were elected ordinary Fellows of the College:—

William Rickward Bacot, M.R.C.S.Eng., London, W.; Harold Graves Bennetts, M.B., C.M., Sydney, N.S.W.; Gerald Hall Lloyd Fitzwilliams, M.B., Ch.B., Newcastle Emlyn, S. Wales; James Methuen Graham, M.B., Ch.B., Edinburgh; William Ezra Graham, M.D., C.M., Ontario, Canada; Duncan Lorimer, M.B., Ch.B., Edinburgh; Peter McEwan, M.B., Ch.B., Kinfauns, Perthshire; William Latto Robertson, L.R.C.S.E., M.B., Ch.B., Edinburgh; William Craig Stewart, M.B., Ch.B., Glasgow, W.; and Stanley Martin Wells, M.R.C.S.Eng., Lima, Peru, South America; and John Pinkerton, M.D., etc., Honorary Physician to his Majesty the King, Gwydyr House, Crieff, Perthshire, was admitted an Ordinary Fellow without examination.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

***Specially compiled for* THE MEDICAL PRESS AND CIRCULAR.**

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Ruptured Pus Tubes.—Mann (*Amer. Jour. Obst. and Gynæ.*, October, 1907).—Clinically ruptured pus tubes may be divided into three classes: (1) Those which rupture into the peritoneal cavity, but in which the pus is restrained by adhesions from setting up a general peritonitis. (2) Those which rupture into some adherent viscus—as the bladder, rectum, intestines. (3) Those in which the rupture is into the peritoneal cavity, the pus not being walled off, and, if virulent, setting up a general peritonitis which acts much like an acute ruptured appendicitis, and usually causes death, unless operative means are employed. It is, however, more amenable to operative measures than peritonitis caused by appendicitis. By far the most common class is the first, the pus escaping forming an abscess which often reaches above the umbilicus, and contains a quart or more of pus, this finally rupturing into the bowel, or peritoneal cavity, or causing death by absorption of toxins. In the second class the danger of secondary infection through the sinus is great, and complete cure is obtained only by removal of the tube and closure of the sinus opening. Of the third class, when symptoms of peritonitis begin, to temporise is, in the writer's opinion, not giving the patient the best chance, and therefore that operation and drainage is in order even in the acute stages. F.

Blood Transfusion in Puerperal Septicæmia.—McKay (*Amer. Jour. Obst.*, October, 1907). The writer reports a case in order to show that the rigors of puerperal septicæmia may be abolished by the transfusion of blood, and to point out the negative effect of enormous infections of antitoxin in this case. The case was admitted to hospital on the fifth day after premature labour; examination of uterine discharge showed a streptococcic infection. Antistreptococcic serum was injected with no result. Having found in previous experience that the antidiphtheritic serum seemed to act well when the antistreptococcic serum failed, he gave her 2,000 units of these sera alternately every four hours. The patient grew steadily worse, and the antitoxin was increased. Rigors began on the fourth day after admission, and continued daily till the joint transfusion of blood and saline. After this transfusion—in which not more than a few ounces of blood was employed—the rigors disappeared for six days, then began again. Thinking that perhaps the salt solution had brought about the happy result, a vein was opened, and thirty ounces of normal saline, to which one ounce of peroxide of hydrogen had been added, was introduced. The patient had a most severe rigor forty-eight hours later, the temperature rising to 106 deg. On the following day ten ounces of blood and twenty ounces of normal saline were transfused, and the patient had no more rigors for twelve days, during which time the pulse and temperature improved, and the patient progressed so rapidly that she was allowed to sit up in bed. Whilst in this posture she fainted, and died in a few minutes. F.

Retention in Utero of Separated After-coming Head.—McKerron (*Jour. Obst. and Gyn.*, October, 1907). Separation of the after-coming head, with retention in utero, is probably a not uncommon accident, while it usually occurs in the case of long dead decomposing children, in whom the tissues are very friable. When the complication occurs the delivery of the head is often a matter of considerable difficulty, and more especially when its extraction has not been undertaken at once, and the os uteri has had time to retract. In view of the comparative frequency of this accident, and of the difficulties that may attend extraction, it is surprising that few writers and no text book refer to it. There are several ways in which extraction of the retained head may be effected. Sometimes expulsion is completed spontaneously, but this is exceptional. The selection of a method of extraction will depend on the extent of dilatation, and on the dilatability of the cervix uteri. When the case is seen at once, before the cervix has retracted, firm downward pressure on the fundus may be sufficient, either alone or combined with moderate traction on the head by the hand or volsella. It is seldom separation takes place at the immediate base of the skull; a part of the cervical column is usually left, and affords a good hold for the hand. Where the cervical vertebræ are torn off, traction may be made in the lower jaw, but this even may tear off. Then delivery must be effected by getting the tip of index finger through the foramen magnum, or by making traction by means of forceps or volsella. When the cervix is imperfectly dilated, or is rigid and unyielding, great difficulty may be experienced in effecting extraction. The cervix must first be dilated, then if a good grasp of the head cannot be obtained with the hand, the volsella, with pressure from above, may be tried; but if much force is required, it is not likely to be successful. owing to the friability of the tissues. Should they fail the forceps may be tried, and its application assisted by steadying the head from above. In the event of failure with the forceps, the cephalotribe or cranioclast, both of which have been successfully used, may be tried. Bergués, in a recent paper on the subject, recommends when the cervix has become retracted, that the head should be fixed by means of a volsella, to which a weighted cord is attached, and allowed to hang over the end of the bed. The continuous traction induces contractions of the uterus, dilatation is thus secured, after which the head can be delivered by traction on the volsella. F.

Ventral Hysteropexy.—Olshausen (*Zentralbl. für Gynäk.*, 1907, No. 41) describes his method modified by his former assistant, Professor Koblanck, which has been employed in his klinik during the last ten years. After opening the abdomen, the skin and adipose tissue are separated from the rectal fascia by a few strokes of the knife at each side of the abdominal incision. A needle with a thick silkworm gut suture is then passed from the superior surface of the bared fascia through the remainder of the abdominal wall into the abdominal cavity. The needle point is inserted about 2 cm. external to the incision, and before passing the needle through, it is important to see that the peritoneum and fascia are pulled well into the incision on each side, so that they may come together easily during the closure of the abdomen. When the needle has been passed into the abdomen it is picked up and guided through the origin of the round ligament, taking up underneath the latter a little of the muscle of the uterine cornu. It is then passed back from within outwards through the abdominal wall, the point being inserted a few centimetres distant from the former point of entry. The suture is then tied. The knot is thus on the superior surface of the fascia. Before the knot is tied one must be certain that the cornu of the uterus lies closely against the abdominal wall. The same proceeding is to be followed on the other side. The operation has been performed hundreds of times in Olshausen's klinik, with excellent results. When it is properly performed it is practically impossible to get a recurrence. The only time a possibility of a recurrence arises is when the silkworm gut suture is tied so very tightly that it cuts through the fascia. The silkworm gut does not alter, therefore it is the best suture material. Olshausen has never seen any hindrance to the development of the uterus during pregnancy after this operation. Neither has he ever seen the operation followed by an abortion. It has been reported that he had a case of intestinal obstruction following this operation, but this is not true. As regards ventral fixation in cases of prolapse of the uterus, he very seldom performs this operation, and then only in combination with colporrhaphy, etc. In such cases, in addition to the silkworm gut suture on each side, he puts in a catgut suture in order to get a broader attachment between the uterus and the abdominal wall. G.

Epilepsy and Pregnancy.—Neu (*Monatssch. für Geb. und Gyn.*, Bd. XXVI., Hft. I.) describes a case as follows:—A primipara, æt. 24, developed epilepsy in the sixth month of her pregnancy. She had 26 fits in 23 hours. As a result she became comatose, and died without regaining consciousness, but with all the symptoms of œdema of the lungs. The patient had suffered before her pregnancy from epilepsy. The author then discusses very thoroughly the relationship between epilepsy and pregnancy. It is his opinion that pregnancy is not the primary cause of the epilepsy, but that epilepsy can be influenced by pregnancy. Whether in cases of pregnancy complicated by epilepsy labour should be induced or not, must be decided by observation of the cases individually. Induction will very often be indicated when the convulsions are very numerous, and always in every case of status epilepticus. G.

Suprapubic Delivery and its Relationship to Other Operations in Cases of Contracted Pelvis.—In a paper on this subject, Frank (*Archiv. für Gynäk.*, Bd. LXXXI., Hft. I.) agrees with the views of Kehrer on the superiority of the low incision in Cæsarean sections. The greatest danger still consists in the infection of the peritoneum from the uterine cavity. If this could be prevented the Cæsarean section becomes an operation free from danger which would certainly reduce the number of operations which are performed for artificially enlarging the pelvis, and also there would be a greater freedom of choice as regards the time at which the Cæsarean section could be performed. The author considers that all this may be obtained by his suprapubic method of delivery by which the abdominal cavity is definitely shut off before the incision into the uterus is made. A transverse incision is made two fingers breath above the symphysis, and directly above the bladder. After the abdomen is opened, the loose fold of peritoneum on the uterus is picked up, cut across transversely, and its upper border is sutured to the parietal peritoneum of the upper edge of the wound. When this has been carefully completed a transverse incision is made in the region of the lower uterine segment. The head is usually spontaneously delivered—one may even wait for spontaneous deliverance by the pains. The author can report from a series of thirteen cases, which were all of a very doubtful nature as regards asepsis, in which the results for the mothers were excellent. It is also his opinion that when suprapubic delivery has been fully developed, it will cause a disappearance in cases of contracted pelvis, of induction of abortion, induction of premature labour, the perforation of the living child, and the sterilisation of women. For infected parturient women whose natural powers have worked in vain, and for whom also the operations for enlarging the pelvis are not without danger, and are also not permissible for every degree of pelvic contraction, this method of delivery is one which may be employed without danger to save the mother and child. G.

Cæsarean Section when the Uterus is Infected—Relying upon the statement of Frank, the Cæsarean section was performed by Veit (*Monatssch. für Geb. und Gyn.*, Bd. XXVI., Hft. I) for two women whose liquor amnii was infected. In order to prevent infection of the peritoneal cavity by the liquor amnii, he sutured the peritoneum of the uterus to the parietal peritoneum after dividing the abdominal wall transversely. Having opened the lower uterine segment, he removed the contents of the uterus and sutured the incisions. He is quite content with the result of the operation in both cases, but advises that the operation shall not be done too early, as good dilatation of the lower uterine segment is desirable. He regards this method of Cæsarean section as most important in cases of decomposition of the uterine contents, as it prevents the entrance of the infection into the abdominal cavity. G.

Complications of Retroflexio Uteri, and their Influence on the Operative Treatment.—In a paper on this subject, Guggisberg (*Zentralbl. für Gynäk.*, 1907, Nr. 41) discusses the ætiology and the symptoms of retroflexio uteri. He then speaks of the complications which may affect the myometrium, the endometrium, the perimetrium, and, further, the adnexa, whose diseases he attributes to the congested condition of the genitals. Among 176 patients who were operated on in the Bern klinik, 60 had complications. The majority of the women dated their sufferings from an afebrile puerperium. The principal symptoms are sacral pain and hæmorrhage. The complications: endometritis, metritis, perimetritis, and, finally, diseases of the adnexa either inflammatory or degenerative. The latter were frequently not diagnosed. As regards the indications for treatment, one must first exclude hysteria, and it must then be determined whether the symptoms are due to the displacement or to the complications. Operative treatment is indicated when the pessary does not work, or causes pain, or when its insertion is not desirable. When operation is decided on, the endometrium must especially be subjected to energetic treatment. Then, having opened the abdomen by the transverse incision, after inspection, and, if necessary, treatment of the adnexa, the round ligaments are fixed to the anterior abdominal wall by one or two silkworm gut sutures which go through the peritoneum, the recti, and the fascia. G.

Alcohol in Midwifery and Gynæcology.—Theilhaber (*Münchener Med. Wochensch.*, 1907. Nr. 4).—In pregnancy, during labour, during puerperal fever, and during lactation, alcohol enjoys the reputation of being a therapeutic agent of value. In all those conditions the author declares that this reputation is unjust, since the action of the alcohol is more injurious than beneficial. It is just as injurious in gynæcology. It causes hyperæmia of the female genitals, it increases the sexual desire, it increases the secretions from the genital system, and also the amount of menstrual hæmorrhage. He forbids, therefore, that it should be given to young girls, to those with diseases producing hæmorrhage and secretions, for all pelvic neuroses, and for the symptoms associated with the menopause. In cases of chlorosis and anæmia there is nothing to be gained by the administration of red wine. Physicians should join in the crusade against alcohol. They can do much by limiting the prescribing of alcoholic drinks. G.

The Chelsea Hospital for Women has received from Earl Cadogan a donation of £500, and the Council have resolved to name a ward of the hospital in memory of its late benefactress, the Countess Cadogan.

Dr. Thomas, the Medical Officer of Health for the Borough of Stepney, reported recently that in the parish of St. George's-in-the-East, the centre of the alien immigration in the East End, the birth-rate for the past fortnight was as high as 52 per 1,000, practically double that for the whole of London.

The annual surgical report of the Netley Hospital shows that 1,282 were treated in twelve months. The number returned to duty was 791, whilst 357 were invalided. The number of deaths was 14, and the balance of admissions remained under treatment. Out of 220 surgical operations no fewer than 190 were completely successful, whilst 17 were partially successful, and 13 were failures, chiefly owing to the weakness of the patient.

A sub-committee decided on Monday afternoon to recommend the Public Health Committee of Dundee Town Council to adopt the Notification of Births Act. The Act provides that notification shall be given to the Medical Officer of Health, and failure to comply with the Act is punishable by a penalty of 20s. The principal idea of notification is that the Medical Officer may send health visitors to any house after the birth of a child, and in this way assist the mother to build up a healthy child at the very outset.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

WHAT IS IN A NAME?

THE limits of the ominous in the physician's name are surely reached in the case reported from Sheffield in the following note:—It may interest you to know that we have here a Dr. Kilham. Also there is a Dr. Reckless, of long-standing connection here. The initial letter of his Christian name being A, for Arthur, his name-plate used to read, "A. Reckless, Surgeon." But he had it altered to his full name.

After this the "Coffins" and the "Philgraves" cease to move our admiration. The Kilham who enters the medical profession demonstrates the invincibility of the human will as few men have done it.—*Daily News.*

ANXIOUS (Exeter).—It is always best, under the circumstances, to submit the case to a consultant. The question of fee could no doubt be arranged to meet the position of the patient.

OSLERISMS.

"EXAMINATIONS are merely the meeting of certain tests. They make a man a mere talking machine or a human monotype."

"Take no thought for the morrow. Let the interest of the day's work absorb all your energies."

"Be sceptical to the Pharmacopœia as a whole. He is the best doctor who knows the worthlessness of most medicine."

"Study your fellow-man—and fellow-woman; and learn to manage them."

"Once get down to the purely business level and your influence is gone, and the light of your life goes out."

DR. S. C. Y.—An X-Ray examination of the limb should undoubtedly be made. Without it there can be no certainty as to the real condition of affairs.

SPES (Birkenhead).—There is nothing in the course pursued by our correspondent which we regard as being derogatory in a professional respect.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 23RD.

ROYAL SOCIETY OF MEDICINE (SURGICAL SECTION IN CONJUNCTION WITH THE CLINICAL LARYNGOLOGICAL, MEDICAL, AND OBSTETRICAL SECTIONS).—5.30 p.m.: Special Meeting. Demonstration (by means of the epidiascope and microscopes):—Prof. Goldman (Freiburg): (1) The Growth of Malignant Disease in Man and the Lower Animals, with Special Reference to the Vascular System; (2) The Diagnosis, by the help of the X-Rays, of Abdominal Malignant Disease, Subphrenic Abscess, Appendicitis, etc.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Pardoe: Clinique. (Surgical.) 5.15 p.m.: Lecture: Dr. D. Drummond (Newcastle-on-Tyne): The Mental Origin of Neurasthenia and its bearing on Treatment.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

THURSDAY, OCTOBER 24TH.

CHILD STUDY SOCIETY (Parkes Museum, Margaret Street, W.).—8 p.m.: Lecture:—Dr. C. A. Mercier: Principles of Education.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. D. Drummond (Newcastle-on-Tyne): The Diagnosis of Thoracic Aneurysm.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson), X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture Demonstration:—Dr. T. R. Whipham: Children's Diseases.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: The Treatment of Eczema in all its Forms.

FRIDAY, OCTOBER 25TH.

ROYAL SOCIETY OF MEDICINE (EPIDEMIOLOGICAL SECTION) (20 Hanover Square, W.).—7.45 p.m.: Council Meeting. 8.30 p.m.: Presidential Address:—Dr. Newsholme: Poverty and Disease as illustrated by the Course of Typhus Fever and Phthisis in Ireland.

ROYAL SOCIETY OF MEDICINE (ELECTRO-THERAPEUTICAL SECTION) (20 Hanover Square, W.).—8.30 p.m.: President's Address.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique. (Ear.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Appointments

BELL, W. W., L.S.A., Clinical Assistant to St. John's Hospital for Diseases of the Skin, London.

BRAY, P. D., M.R.C.S., L.S.A., Clinical Assistant to the Chelsea Hospital for Women.

BROWN, A. CARNARVON, M.R.C.S., L.R.C.P.Lond., Resident Medical Officer at the Farringdon General Dispensary and Lying-in Charity, Holborn Circus, London.

COWAN, J., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the New Galloway District of the county of Kirkcudbright.

DAVIDSON, JAMES A., M.B., Ch.B.Aberd., Junior House Surgeon at the Croydon General Hospital.

JONES, ERNEST, M.D., B.S.Lond., M.R.C.S.Lond., D.P.H.Cantab., Registrar and Pathologist to the West-End Hospital for Diseases of the Nervous System.

LAVERICK, F. R. H., M.D., B.S.Durh., House Surgeon to the Torbay Hospital, Torquay.

PORTER, W., M.B., B.S.R.U.I., Certifying Surgeon under the Factory and Workshop Act for the Portrush District of the county of Antrim.

RICE, D., M.D.Brux., M.R.C.S., L.R.C.P.Lond., Resident Medical Superintendent at the Norwich City Asylum.

THOMAS, W., M.R.C.S., L.R.C.P., Medical Officer and Public Vaccinator for the Third District by the Liskeard (Cornwall) Board of Guardians.

TURTON, EDWARD, M.D., Ch.B., B.Sc.Vict., M.D.Leeds, M.R.C.P. Lond., Honorary Physician to the Hull Royal Infirmary.

WARREN, A. C., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Chelsea Hospital for Women.

Vacancies.

Bristol Royal Infirmary.—House Surgeon. Salary, £100 per annum, with apartments, board, and laundry. Applications to W. E. Budgett, Secretary and House Governor.

Bristol Royal Infirmary.—House Physician Salary, £100 per annum, with apartments, board, and laundry. Applications to W. E. Budgett, Secretary and House Governor.

Rochester St. Bartholomew's Hospital.—House Physician. Salary, £110 per annum, with board and residence at the Hospital. Applications to Thos. Crockford, Clerk to the House Committee.

Lancaster County Lunatic Asylum.—Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to Medical Superintendent.

Birmingham General Dispensary.—Resident Surgeons. Salary, £150 per annum, with furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.

Holborn Union.—Assistant Medical Officer. Salary, £100 per annum. Applications to J. Allan Battersby, Clerk to the Board, Guardians' Offices, 53, Clerkenwell Road, E.C.

The Children's Hospital, Dublin.—Assistant Surgeon. Immediate applications to Hon. Sec., Temple Street.

Births.

RICHMOND.—On Oct. 20, at 57, Drayton Gardens, London, the wife of W. Stephenson Richmond, M.R.C.S.Eng., of a son.

JEANS.—On Oct. 13th, at 43 Canning Street, Liverpool, the wife of Frank A. G. Jeans, M.B., F.R.C.S., of a son.

WOLFE.—On Oct. 16th, at Hanwell, London, the wife of John Henry Wolfe, M.R.C.S.Eng., L.R.C.P.Lond., of a son.

WOOD.—On Oct. 16th, at Emotts, Penshurst, Kent, the wife of W. Charrington Wood, M.D.Lond., F.R.C.S.Eng., of a daughter.

Marriages.

COLLINS—BRANDT.—On Oct. 16th, in All Saints' Church, Cheltenham, J. Rupert Collins, M.D., to Agnes Mary, younger daughter of Mr. Francis Brandt, J.P., (I.C.S., retired), of Cheltenham.

EVANS—DAVIS.—On Sept. 21st, at Bombay Cathedral, Major Usher W. Evans, R.E., second son of Usher W. Evans, M.D., Dy. Inspect.-Genrl., of Clifton, to Gertrude Julia, younger daughter of the Rev. W. Smith Davis, late Rector of Steeple Gidding, Huntingdonshire.

FLOOD—PITKIN.—On Oct. 17th, at St. Mary's, Shapwick, Somerset Frederick Grey Flood, M.R.C.S., L.R.C.P., of Wymeswold, Leicestershire, only son of the late Alfred John Flood, banker, of Witney, Oxon., to Ruth, youngest daughter of Rev. J. Pitkin.

HARRIES—LYON.—On Thursday, Oct. 17th, Arthur J. Harries, M.D., of 30 St. James's Square, Pall Mall, London, S.W., to Clara, widow of the late Reuben Lyon, formerly of Johannesburg, South Africa. No cards.

KINGSBURY—HOLLAND.—On Oct. 17th, at St. James's Church, Paddington, William Neave Kingsbury, M.R.C.S., L.R.C.P., eldest son of W. G. Kingsbury, of Ealing, to Marion, younger daughter of the late George Holland, of Sandbach, Cheshire.

Deaths.

HOILE.—On Oct. 18th, at 112, Oakwood Court, Kensington, Lieut.-Col. Edmond Hoile, M.D., late of the 17th Lancers.

SIMON.—On Oct. 16th, at the residence of his daughter, Whitehall, Pembroke, George Simon, M.D., Lt.-Col. A.M.S., Hon. Brig.-Surg., aged 70 years.

STEPHENS.—On Oct. 17th, at Preston, Brighton, Helen Wordsworth, wife of J. Stephens, L.R.C.P., late of Old Steine, Brighton.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, OCT. 30, 1907. No. 18

NOTES AND COMMENTS.

The Speed Limit. How fast may a medical man drive his motor? This question is one which is likely to be more and more debated in the course of the next few years. The bulk of the profession has little enough sympathy with the road-hog, be he medical or lay, but just as the King is above the law, so the dictates of humanity are higher than police regulations, and in certain cases constitute a legitimate excuse for exceeding the speed limit. In the South-Western police-court recently the chauffeur of a medical man was summoned for driving a motor containing his master at an excessive speed on the road beside Wimbledon Common, the police estimate placing the pace at 28 miles an hour. The owner did not deny the soft impeachment, but boldly claimed his right to travel as fast as he could along an open road when called to an urgent case of illness. Mr. de Grey, the magistrate, with good sense, recognised the force of the argument and dismissed the summons. We beg to congratulate him on his discrimination. Medical men have several times been summoned under similar circumstances in different parts of the country, but we do not remember ever to have heard it admitted by the Bench that the excuse of humanity was reasonable. This case, then, should prove a valuable precedent to country Shallows.

Justifiable Excess. BUT if this privilege is claimed by the profession, and is granted to them by the sense of the community, it is most important that it should never be abused. A form of travelling which at the present calculated rate, kills a thousand persons and maims over fifty thousand a year in this country, adds a very real danger and terror to the lives of the mass of the people, and improper and reckless driving certainly deserves the most heinous penalties. If then a medical man claims exemption in case of emergency, it might not be a bad plan if he were summoned whenever the legal speed was exceeded, and if excused by the magistrate on the ground of an urgent call to a patient, the latter were made to pay all the expenses of the prosecution, together with an adequate fee to the doctor for the loss of time involved in attending the Court. By some such means as this it might be possible to regulate the number of "urgent" summonses to patients, and thus relieve the general practitioner's life of its heaviest load.

From Christian Science to Medicine. IT has been thought a matter of such moment to the world that a Christian Scientist in America should call in a doctor, that a Marconi wireless message was employed to flash the fact to this country. The doubting sister in question, Mrs. Augusta Stetson, is, it happens, a candidate for the leadership of the faithful in the presumably impossible event of Mrs. Eddy being called "up higher"; at any rate, she is regarded as a kind of second string, and her bad example is likely therefore to have a powerful influence on the shaky members of the flock, though doubtless amongst the real believers it will be regarded merely as an act of magnaminity such as one practitioner might show to another. The Christian Scientists in America have gradually been adding to the occasions on which a doctor may be called in ever since the day when Mrs. Eddy had toothache, and was found Nicodemus-like repairing to the dentist. Some three years or so ago medical aid was permitted in the case of infectious diseases, and lately we understand doctors were officially permitted when Christian Science had failed. Perhaps we shall soon find these enthusiastic idealists ranging themselves under the orthodox banner, and being sent by medical men to persuade their troublesome patients that there is nothing wrong with them except *febris imaginata*.

Vivisection Commission's Difficulties. WE find that in these notes the other day we did something of an injustice to the *Morning Leader* when we chaffed it about the "Vivisection Horror" that it had dug out of the report of the Royal Commission on Vivisection. We stated then that that ably-edited journal had adopted the short and picturesque way of supporting its views on experimentation by pasting large upon its sheet the incident of the four puppies. Our attention has been called to the fact that two articles in which Mr. Coleridge's evidence was dealt with had also appeared. We have read these articles with interest, and can certainly say that the best is made of the extraordinarily puzzling statements of that doughty protagonist. But we cannot say that we think the Commissioners have been greatly helped along their way. It is the duty of Royal Commissioners eventually to make a report, and we do not envy the present ones their task. There are only two suggestions that appear to us possible, namely, an increase of the inspectorate, and some alteration in or addition to the body that advises the Home Office as to candidates' claims for licenses. No doubt it is humanly impossible for the present inspector, Professor Thane, to be present at a tithe of the experiments performed; indeed, to compass that end a small army of officials who understand the points involved in anæsthesia, physiology, pharmacology, and pathology, would be needed. At any such proposal we fancy the economists would cry out.

Usque ad Aras. EXPERIMENTERS themselves having nothing to fear from increased publicity would have no objection, *quâ* experimenters, to the presence of any number of inspectors, though as taxpayers they might be inclined to grumble. Then, too, they could have no cause to complain of any impartial body, which understood the issues at stake, giving advice to the Home Office on the capabilities of would-be experimenters to ascertain truth from experiments and to carry them out with humanity and skill. But what better body could be chosen than the present one? It would hardly be contended that a committee composed of Mr. Coleridge, Miss Lind-af-Hageby, Miss Beatrice Kidd, and Dr. Hadwen, would be competent for the task. Besides, after the committee had been sitting a month, we fear that as in the tragedy of the Kilkenny cats nothing but tails would be left.

The M.A.B. and its Matrons. THERE is a sad time in store for the Metropolitan Asylums Board. That body, it appears, proposes that the matrons of its hospitals shall no longer be first-class officers, but shall serve their common task in the less Olympian sphere of the second class. The full heinousness of this proposal will not be apparent to outsiders till it is realised that this revolutionary proposal actually means that the matron is to rank no longer with the medical superintendent, but with the assistant medical officers, and that the nursing administration of the hospials will be pulled down to the level of the mere medical treatment of patients. No wonder that an emergency meeting of the Matrons' Council for Great Britain and Ireland was called at forty-eight hours' notice and that the room was crammed to suffocation. No wonder that the fair president proposed a resolution calling the attention of the public, the Local Government Board, and the nursing profession to this attempted degradation. No wonder that the motion was carried with the utmost enthusiasm. But the matrons are not going to stand any nonsense. They threaten the unlucky Board with a boycott, also agreed to unanimously, and they have represented to the President of the Local Government Board the advisability of receiving a "small deputation," lest he should not understand the "widespread and prejudicial effects" that the change will cause.

A Plea for Justice. INDEED, the matrons are so excited that they say they feel themselves incompetent to show clearly in a letter all that they feel, and it really seems that if Mr. Burns declines to override the Metropolitan Asylums Board we shall have to be on the look out for relays of mounted police to protect him from the suffragette-like importunity of these indignant ladies. At any rate, let us hope that in this crisis in the affairs of the nation Mr. Burns may keep a cool head, and that he may be led to perceive the anomaly of allowing the matrons to fall so low as the rank of mere doctors. But we would implore the Metropolitan Asylums Board, if it consents to this "degradation," that it will at least grant the matrons the privilege, now so sumptuously enjoyed by the assistant medical officers, of being "rationed as a principal officers." Dreadful things may happen if the matrons are let down in rank, but who can conceive the result if they were contemporaneously docked of their tea and sugar?

A DEATH from cholera has taken place at Lemberg, and has caused great alarm among the authorities, who have promptly formed a cholera commission. Four deaths have already occurred at Kieff.

LEADING ARTICLE.

THE TUBERCULOSIS PROBLEM IN IRELAND.

IT is a serious matter to the health of Ireland that sanitary affairs in that country are taken so lightly. In nearly every point as regards sanitary administration she is far behind the sister countries, though, indeed, in one particular she shows an example which England might well follow. We refer to protection against small-pox. Ireland has a thoroughly vaccinated population, and it is gratifying that the fads and superstitions which in England have led to such disastrous outbreaks of small-pox, are in Ireland without any upholders. In other particulars Ireland is not merely behind the rest of the Kingdom, but behind the civilised world. Her capital, with the sinister boast of being the most unhealthy in Europe except St. Petersburg, does not possess a whole-time medical officer of health! This seeming incapacity to deal with sanitary problems is nowhere better exemplified than in regard to tuberculosis. The death-rate from tuberculosis has in Ireland shown a slight increase during the past forty years, whereas the death-rate from the disease in England, Scotland, and Germany, has diminished by nearly a half. The number of deaths in Ireland each year from tubercular diseases is nearer twelve than eleven thousand, and up to the last year or two it is the bare fact that nothing was done to face the problem. There is no need to attempt to fix the responsibility for this scandal, since everyone concerned is responsible in some degree. The medical officers of health are more to be pitied than blamed, on account of the conditions of their service. Their sanitary work is secondary only to their work as dispensary medical officers, and they are in all cases dependent for their living on the good-will of the people among whom they live. Many of them have done in this, as in other directions, noble work, but power to deal with the problem as a whole has been lacking. Of the sanitary work in the large towns such as Dublin and Belfast it is sufficient to say that satisfactory results have been absent. The local sanitary authorities have, in fact, up to within the last year or two, ignored the whole question. No attempt has been made to erect sanatoria or to disinfect houses where tubercle has occurred, and nothing has been done to educate the people. The Local Government Board, which exercises a general supervision over the local sanitary authorities, has occasionally issued a circular on the subject of tuberculosis, but has never seriously attempted to make its advice effective. It would seem, however, as if a general awakening might be at hand. Within the past two years the public has taken some interest in the matter, and schemes are on foot in many counties for the erection of sanatoria. The local bodies are beginning to discuss practical measures, and discussion is a means of education. Popular lectures have been delivered in many centres, and instruction in hygiene is given to teachers. Since her arrival in Ireland, Her Excellency the Countess of Aberdeen has shown a marked interest in the subject, and, as our readers are aware, her interest has borne fruit in the Tuberculosis Exhibition at present open in Dublin. Moreover, the Local Government Board has declared that it is alive to the importance of the subject, and has devoted two pages to the question in its Annual Report. At the present moment the Tuberculosis Exhibition has aroused much interest, and the series of lectures organised in connection therewith have been the means of interesting and educating large numbers of the general public. What is requisite is to make use of this general interest before it wanes. It is necessary to have a definite programme ready, and, fortunately, there need not be much dispute about the terms of it. The first thing necessary is to educate the people in the means to be adopted in every home to prevent the spread of the disease. The value of fresh air and cleanliness, and the need for proper precautions where the disease is present, must be impressed on every man, woman, and child in the country. In this work of education the chief, but by no means the entire, responsibility must rest with the members of the medical, clerical, and teaching professions. Along with this, steps must be taken to provide for those who are already diseased. Sanatoria, isolation hospitals, and dispensaries must be established where required, and it must not be forgotten that money spent in this direction is soundly invested, for the capital of a nation is its healthy sons and daughters. Finally, the housing problem must be settled. We believe that, given determination to deal with it on such lines, the tuberculosis problem in Ireland is capable of arrangement, and the next generation should be in a fair way for settlement.

THE BRISTOL INFIRMARY DEADLOCK.

The deadlock at the Bristol Royal Infirmary, much as it is to be regretted from many points of view, nevertheless brings to the front various points of vital importance to the future welfare of medical charities in the United Kingdom. It is too much the fashion of the governing boards of such institutions to override the deliberate and expressed wishes of their medical staffs. After all, the services of the latter are purely honorary, and they are plainly entitled to some say in matters which intimately concern the ordering of their private lives. In the present controversy the governors of the Royal Infirmary were requested to attend the half-yearly meeting of the Board to vote on the proposed alteration to Rule 36, which laid down that no member of the staff should hold any further appointment other than in the local University or Medical School, or engage in other than consultant or special practice. We are informed on good authority that when this proposal was discussed in committee it was thought that the Faculty had given their approval; and so they had, with the following addendum :—"This rule, as it stands, seems unfeasable; we assume that certain exceptions are contemplated." As a matter of fact, that opinion was not before the Committee, and the exceptions have never been formulated or discussed. The reason for this latter curious fact is, we learn, that the President would not permit discussion. Accordingly, the bald rule was passed, although in obvious opposition to the medical staff. The *fons et origo* of the whole affair appears to lie in the determined resolution of a strong President to carry the rules. That gentleman, Sir George White, has already done a great deal for the Infirmary, and in the event of his present wishes being carried into effect, we understand will do a great deal more. It is clear, however, that the rule cannot be passed without the resignation of the medical staff. If Sir George White is prepared to face that contingency he is assuming a position of very grave responsibility. Approaching this matter from a professional point of view, we own that our sympathies lie wholly with the staff. We feel that they are asserting the ordinary rights of medical men who hold these honorary posts, and we may congratulate ourselves that the safeguarding of important ethical principles is fortunately upon this occasion vested in strong and able hands. If once it be conceded that the benefactor of a medical charity is entitled to play fast and loose with the private lives of the honorary medical staff then the prestige of such institutions will indeed receive a deadly blow. The medical profession is long-suffering and anxious to work in harmony with all philanthropic schemes. It is too much, however, to ask them to sacrifice their independence of thought and action at the bidding of autocratic presidents and boards. The ultimate decision lies in the hands of the governors, and we shall be disappointed if the latter do not prefer to uphold the legitimate and strictly reasonable wishes of the medical staff, even should there be a prospect of some temporary loss of material prosperity to an ancient institution.

CURRENT TOPICS.

The Irish Local Government Board and Consultants' Fees.

The Irish Local Government Board is a body which, as a rule, endeavours to do its best under difficult circumstances, and which undoubtedly gets numerous opportunities of showing its powers. Indeed, so numerous are these opportunities that we should have thought it unnecessary for the Board to go out of its way to create difficulties. Yet, apparently, such is its desire. The latest task which this voluntary Sisyphus has set itself is that of regulating the fees charged by consultants over whose actions they have no more control than have we over the salaries of the eminent gentlemen who comprise the Board. On a recent occasion, a well-known Dublin Hospital surgeon was called into consultation by the medical officer of a country workhouse hospital to see a patient who had received a compound fracture of the skull and severe injury to the spine, the result of a fall off a bicycle. In order to give the patient the benefit of his advice the consultant had to travel some twenty miles, and was away from his practice for four hours. As a result of the united efforts of the two medical men the life of the patient was saved. The consultant named five guineas as his fee, and the amount was ordered for payment by the local Board of Guardians. Such Boards, even in Ireland, contain cranks among their number, and the particular crank in this case was a gentleman whose views expressed themselves in the dicta that five guineas were too much to pay any doctor, and that their medical officer had no right to summon a consultant from Dublin when he could have called in one of his local colleagues. With this gentleman's views it is unnecessary to deal. It is probable that if he required medical advice himself he would seek what he considered was the best advice available, and it is obvious that he is determined that the poor under his charge shall not similarly benefit, since it is impossible for any medical man to be a good general practitioner and at the same time to have the intimate special knowledge which is possessed by a consultant, if he is one in more than name. The crank accordingly wrote to the Local Government Board to protest against the payment of the consultant's fees. The Local Government Board in turn wrote to the local Board, and in the letter, in which it asked for information regarding the case—a very proper request—it stated "that five guineas certainly appeared to be an unusually high sum to pay a doctor for consultation fee." Sisyphus must roll his stone up the hill; it is for that he is paid, but why, for the sake of the plaudits of the onlookers, should he increase his difficulties by occasionally pushing it in the opposite direction? The Local Government Board has no power whatsoever over the fee charged by a consultant, brought in as was the consultant in the present case, and why it should go so far out of its way as to make an incorrect and unjustifiable statement about a matter over which it has no control is one of those often-occurring puzzles with which "Boards" like to perplex the public. Much as we should like to support the Irish Local Government Board in a good cause, when by its actions it departs so far from its proper sphere as to try to lay down the fees to be charged by medical men over whom it has no control, especially when those fees are below rather than above the average, and when it indirectly endeavours to inculcate into the minds of local guardians that expert advice is a luxury for the rich, and is not a necessity for the poor, we cannot but feel that "quem Deus vult perdere, prius . . ."

School Board Medical Certificates.

THE question of payment for School Board certificates deserves the deep and earnest attention of all bodies concerned in protecting the interests of medical men. At present medical practitioners for the most part sign these documents free of charge, either in hospital or private practice, and thus add to the already swollen volume of gratuitous service conferred upon the community. As usual, the organisation that demands the certificates makes no provision for remuneration of the responsible professional man who grants the document. Obviously, the majority of parents are unable to pay fees for certificates. Why should not the State pay for documents which it finds to be vital to the safe and proper conduct of its schools? What possible excuse can there be for declining to pay? While it is hard to find an answer to that question, it is easy enough, on the other hand, to imagine that the unbusinesslike medical profession has never asked collectively to be paid for its services. If the medical staff of one dictrict or of one hospital decline to issue unpaid certificates, they are at once stale-mated by neighbours who are ready to continue the gratuitous service. It seems more than likely that if the medical profession united and took a firm ground upon the matter, that the School Board authorities throughout the kingdom would be reduced to reason within a short period of time. The Colchester medical men intend to try, for they have notified the Education Committee of the town that they will in future refuse to sign School Board certificates except at a fee of half-a-crown apiece. The Committee some time ago offered eighteenpence. This result shows what may be done with a little courage and enterprise.

The Administration of Anæsthetics for Unqualified "Dentists."

WE have received a letter from the secretary of the Irish Branch of the British Dental Association calling our attention to the efforts of the Association to stop the administration of anæsthetics for bogus "dentists" by medical men. We are aware that such a practice exists, but we venture to think that it is not of such important dimensions as the Association seems to imagine. Still, even if only isolated cases occur, the fact remains that it is not only forbidden by the General Medical Council, and grossly unfair to the dental profession, but that it is also a short-sighted policy from the point of view of the medical profession itself. How can the latter profession hope to obtain the support of the public in its struggle against quackery and unlicensed competition, if it directly or indirectly supports similar competition in another and allied profession? The excuse which we have heard offered, that the "dentist" for whom the anæsthetic has been administered is capable of doing his work, or is a highly respectable individual, has nothing to do with the case. If such is a true description of him, then it is a great loss to himself and to the public that he has never become a registered dentist. Medical men cannot take these points into consideration, but, rather, are bound by every consideration of honour and of professional interest to refuse to have any professional dealings with unregistered dental practitioners. We are glad to see that the Irish Branch has brought the matter before the General Medical Council, and that the latter body has communicated with alleged offenders. We trust that the warning thus given by the Medical Council will be sufficient, as it would be a most unpleasant occurrence if more serious action had to be taken. *En passant* we take the opportunity of again pointing out to correspondents that if they wish their communications attended to, they must send them, in the case of Great Britain, to the London office, or in the case of Ireland, to the Dublin office.

Medical Examination of Engine-Drivers.

OF all callings in the world, that of an engine-driver demands the most perfect alertness, both of mind and body. A moment's delay in perception, a moment's indecision or inattention, and a hundred lives may be hurled into eternity. Under such circumstances it is a standing monument to the listless apathy of the British public that they do not insist upon a reasonable limit for the hours of duty of railwaymen. Hardly less amazing is the fact that they have not long ago made it compulsory for the railway companies to maintain a constant medical supervision of enginemen and guards. Only last week an inquest held at Paddington revealed the fact that an engine-driver was affected with locomotor-ataxy, and that he had returned to work shortly after an attack of broncho-pneumonia. Medically speaking, to place a man suffering from locomotor-ataxy in charge of a train would be little short of criminal recklessness. On general grounds, we maintain that every driver, stoker, guard, and signalman should be examined medically, say, once every three months. Nor should he be permitted under any circumstances to resume his duties after an attack of illness without a special medical certificate of his fitness. In the face of many serious railway accidents of late it is to be hoped that the House of Commons will enquire into the simple but highly important matter of the periodical medical inspection of railwaymen.

Medical Heroism.

The institution of a special decoration for heroism amongst medical men might be worth some little attention of the powers that govern such matters. Certainly there would be no difficulty in finding worthy recipients of any such distinction from time to time amongst members of our profession. The latest reported instance of self-devotion of this kind comes from Glossop, where a well-known Belfast physician, Dr. Thomas Waddell, has once more performed the now familiar feat of sucking a tracheotomy tube free of diphtheritic membrane. The details have a familiar ring. The patient was the only child of a poor woman, and the instant clearing of the tube was a matter of life or death. The child got well, and his rescuer contracted the disease, from which we are glad to say he has since recovered. From a philosophical point of view it may be argued that Dr. Waddell was not justified in risking his own valuable life for the sake of that of an infant in which the value was merely potential. Apart from intellectual analysis, however, we are proud to claim him as a fellow member of the profession in which unswerving self-sacrifice and obedience to the call of duty constitute the supreme law.

Norman Kerr Memorial Lecture.

The problem of inebriety was dealt with by Dr. Welsh Branthwaite in his second Norman Kerr Memorial Lecture in an extremely interesting and useful fashion, and it would be good if this puzzling question were always handled in the same detached and unbiassed fashion. Dr. Branthwaite shows that the inebriate, properly so called, is a person who cannot live soberly; that, indeed, is his definition of an inebriate, and that in a large proportion of cases he is suffering from obvious mental defect. Of persons confined in inebriate institutions he finds no fewer than 62 per cent. are actually mentally defective, and he adds that if he had his own way he would class practically the whole number as lacking mental competence, but he fears to do so lest he should be taken for a special pleader. A fair proportion of persons committed to retreats by magistrates are actually certifiably insane, 15 per cent. indeed, and the majority of these have become alcoholic because of their tendency to insanity, and not insane as the result of alcoholism. In the more or less defective group—constituting 46 per cent. of the whole—nearly all the patients show definite stigmata of degeneration, in cranial conformation, general physique, or conduct. The mental symptoms exhibited by such include impaired development of the moral sense, imperfect control over impulse, and defective judgment. From a practical point of view all these inebriates are hopeless as regards cure. Of the 37 per cent. of "average mental capacity" Dr. Branthwaite says that by no means are all these improvable, for though not actually and demonstrably defective, they are all of persons of impulse and dwarfed moral responsibility, although they have some qualities which may be appealed to. In the redeemable class Dr. Branthwaite has found that moral influences, such as religious emotion, the impress of a strong character, and even faith cures, are at times successful, whilst he speaks hopefully of the reinforcing value of medicinal treatment, and, naturally, of hygienic measures, for the reformed drunkard good social environment and total abstinence are imperative.

Quarterly Journal of Medicine.

We have a new medical contemporary to welcome, namely, the "Quarterly Journal of Medicine," and we can honestly say that if it keeps up to the standard of its first number, even if it does not have a large circulation, it will have a decided influence for good in stimulating authors to produce papers of equal merit. Although not specificially stated, we gather that the new "Quarterly" is practically the journal of the new Association of Physicians of Great Britain and Ireland, which held its first meeting last May; at all events, the papers in the number before us are those communicated to that meeting. The editors are six in number: Professor Osler, Dr. Rose Bradford, Dr. Garrod, Dr. Hale White, Dr. Hutchinson, and Dr. Rolleston, and as they have the assistance of twenty-five assistant editors, we judge there will not be much fear of failure. The Quarterly is beautifully printed on really good paper, with plates and diagrams of great excellence, but considering the cost of each number is 8s. 6d., that is not to be wondered at. Naturally, in a journal of this type the contributions are mostly records of purely scientific work or of rare individual cases, but they are all very interesting, and of a high level of merit. We have been much interested ourselves in a paper of Professor Osler's "On Multiple Hereditary Telangiectases, with Recurring Hæmorrhages," which describes a condition not infrequently met with, and up to the present very inadequately described, but perhaps the most important contribution is that by Dr. E. I. Spriggs "On the Excretion of Creatinin and Uric Acid in some Diseases involving the Muscles." We wish our contemporary all the success it so well deserves.

PERSONAL.

Mr. C. T. Street has been elected President of the Wigan Medical Society for the coming year.

Dr. R. J. Probyn-Williams, President of the Society of Anæsthetics, took the chair at the annual dinner of that body on October 18th.

Dr. S. J. Gee presided on October 22nd over the first meeting of the Medical Section of the Royal Society of Medicine.

Professor Howard Marsh has been elected Master of Downing College, Cambridge, in succession to Dr. Alexander Hill, resigned.

Mr. J. Howard Mummery gave the inaugural address at the meeting of the Odontological Section of the Royal Society of Medicine on Monday last.

Dr. J. Ritchie has been appointed an examiner in Pathology at Cambridge University, and Professor R. Stockman an examiner in Pharmacology.

Mr. A. J. Balfour, M.P., performed the inauguration ceremony of the new building in connection with the Royal Victoria Hospital for Consumption, Edinburgh, on Friday last. The hospital was founded in 1887 as a memorial of Queen Victoria's Jubilee.

A CLINICAL LECTURE
ON
THE PREVENTION OF FEVER IN THE PUERPERIUM. (a)

By H. OLIPHANT NICHOLSON, M.D., F.R.C.P.E.,

Assistant Physician to the Royal Maternity Hospital; Late Obstetric Physician to the New Town Dispensary, Edinburgh.

GENTLEMEN,—In the near future it will fall to the lot of most of you to engage in general practice, and in this sphere of work midwifery will claim a large share of your attention. Midwifery work not only taxes the bodily strength severely, but to men of high-strung sensibility the anxiety associated with it is very great. When you have to undertake the entire responsibility of your midwifery cases you will worry especially over two things—hæmorrhage during the third stage of labour, and fever in the puerperium.

It is difficult for you to realise at present, working as you are in hospital practice and under supervision, the kind of anxiety that is occasioned from these two causes in the attendance upon labour cases. The constant fear of post-partum hæmorrhage makes midwifery work impossible for some men, and drives them into other branches of the profession. I am not going to speak about hæmorrhage to-day, but only wish to say that although serious flooding after labour is a terribly trying ordeal for the practitioner to pass through, and severely tests the strongest nerves, still it is not the right attitude to take up to admit that one is afraid to face it and deal with it. I do not think that any form of anxiety can be so intense as that experienced by the physician during the management of a dangerous post-partum hæmorrhage. It is then, gentlemen, that you will realise the heavy load of responsibility which you bear, when you see the woman who relied upon you to conduct her safely through her confinement lying exsanguine and possibly all but moribund. The terrible anxiety associated with such hæmorrhage is, however, of comparatively short duration, and I wish you particularly to remember that a fatal result is quite exceptional. In almost every case a competent, cool-headed man can control the bleeding.

The other source of worry in midwifery work is the occurrence of fever in the puerperium. You notice that I say fever in the puerperium, and not puerperal fever, and for this reason—that any rise of temperature in the early days of the puerperium will cause you anxiety. You cannot say precisely what is the significance of the raised temperature, and you will generally find yourself taking the worst possible view of the abnormal symptom. Fever in the puerperium, whatever its origin, if it is moderately high and lasting, will greatly disturb your peace of mind, and the anxiety occasioned by it will continue so long as the temperature is elevated.

When you realise how important it is, both as regards success in your practice and pleasure in your work, that you should have a practically afebrile puerperium after each labour, you will understand why I wish to take the earliest opportunity of discussing some of the measures whereby such results can be secured. My remarks relate to the safeguarding of your patient from fever in the puerperium which is due to septic infection. You cannot, of course, always control the other conditions which cause a rise of temperature at this period, but these are generally unimportant and harmless compared to true septicæmia.

While it is a well-established principle that antiseptic measures are absolutely essential in the practice of obstetrics as a means of preventing septicæmia, still, as regards details, the technique varies considerably in the hands of different practitioners. First let me impress this fact upon you, for it is an important one—namely, that the antiseptic treatment of a midwifery case is one thing, and that of a surgical case something quite different. Do you imagine that it is possible in routine practice, or even in a maternity hospital, to sterilise the external genital organs and vulvar skin of your patient as completely as you can the skin of the abdomen previous to an operation? It is quite impracticable, and even assuming that you can get these parts relatively aseptic, there is also this difference from a mere surgical procedure—that you have to keep everything in an aseptic condition for a week or ten days at the least, in order to avoid the introduction of infective material from without. You must remember also that your own responsibility for the antiseptic treatment of the patient terminates at the end of the labour; the nurse or the next-door neighbour undertakes to carry out similar precautions during the puerperium. And yet, gentlemen, it is the rule for things to go well. I am putting the matter before you in this way because I am bound to confess to you that the safety of the lying-in woman does not depend upon *real* surgical cleanliness on your part; if it did, the mortality from sepsis would be too appalling to think about. Practically speaking, something far short of this seems to be sufficient to enable one to obtain a normal puerperium even after the most complicated labour. Now, although you know that you cannot render your hands and the vulvar orifice of your patient surgically aseptic, please do not conclude that you can afford to neglect one little detail in the attempt to do so. You simply must not, or, sooner or later, disaster will certainly follow. No precautions which both you and the nurse take to prevent infection can be too elaborate, and the more systematic they are the better. In the present state of our knowledge it is criminal to conduct even a perfectly normal labour without the most careful preparation of the hands, and the proper disinfection of the vulva and vaginal entrance is of quite equal importance. Neglect to cleanse the vulva is unpardonable, and yet I do not advise you to shave it and scrub it, as the gynæcologist would do before performing vaginal hysterectomy. That is quite unnecessary, and if you attempt to carry out such thorough disinfection your midwifery list will never be a large one. Simply remember that the cleansing of the skin around the vulva by means of a strong antiseptic solution is absolutely essential if you hope to keep your patient free from septic infection.

At the best, as I have told you, neither your hands nor the vulvar parts will be surgically aseptic, but, with reasonable precautions, they are sufficiently clean to make it very unlikely that infective material will be introduced into the vagina and uterus during an ordinary examination, or in the course of any operative interference.

I do not wish you to run away with the idea that you can in this way keep the vagina free from micro-organisms, because you can never do so. You can keep it free from dangerous pus-producing organisms—streptococci and staphylococci—and that is all you need care about. Bacteria are always present upon the vulva and in the lower third of the vagina, and some of these organisms, if implanted in the uterus by the examining finger, are doubtless able to set up putrefactive changes if there is any material present suitable for bacterial growth. Fortunately, in the majority of cases, there is no suitable culture medium, and I want to particularly impress upon you that it is for this reason, and also because the normal vaginal secretions possess strong protective powers against bacteria, that the puerperal woman comparatively seldom goes septic. You must never flatter yourselves that the antiseptic precautions you have adopted—absolutely necessary as they are—deserve all the credit in the successful recovery of your patient; the normal protective mechanism against infection is an enormously important factor to take into account. A knowledge of this carries with it a warning against the use of the antiseptic vaginal douche. Before labour, such a proceeding is, in my opinion, almost always more likely to be a source of danger than a safeguard; and routine douching after labour, I sincerely trust, will soon be entirely abolished. It is positively dangerous, and is often the surest way to court disaster in the way of sepsis.

(a) A Lecture delivered at the Royal Maternity and Simpson Memorial Hospital, Edinburgh.

Safeguarding Against Septic Infection.

I shall describe to you what I regard as the best and simplest means of safeguarding the parturient woman from septic infection. The methods are simple in the extreme, and can be carried out in the poorest cottage in town or country.

All the methods commonly adopted for the protection of the lying-in woman from infection have one aim—they are all concerned with keeping bacteria out of the genital canal. Rigid precautions are therefore taken to prevent the introduction of infective material during vaginal examination and during operative interference. This is all very well, and is, of course, very important; but in my opinion too little attention has been given to the equally important matter of making sure that the involution of the uterus goes on normally in the puerperium. It is admitted by everybody that there is a very close connection between a relaxed enlarged uterus and the occurrence of septic trouble, and the very best safeguard against this is that the uterus should remain well contracted during the whole course of the puerperium. I invariably adopt measures to secure efficient uterine involution, and, in the prophylaxis of puerperal morbidity, I have no doubt in my own mind how important this part of the treatment is.

To come to practical details, gentlemen, let me first tell you how to avoid introducing infective material into your patient's genital tract.

You can do this, as I have already told you, by the proper disinfection of your hands and of the skin around the vulvar orifice, and you require nothing more than a good nail brush, soap, and some reliable antiseptic. In the poorest house you can always obtain soap and a couple of basins of hot water. Take off your coat, turn up the sleeves of your shirt, and, if possible, put on a long sterilisable overall. Then scrub your hands, arms, and nails very thoroughly in soap and hot water. This means that the washing process lasts for nearly five minutes, and if you can get two changes of water, so much the better. When the nails are softened, trim them and clean them, if necessary, before soaking the hands in the antiseptic solution. Next comes the question of what antiseptic you are going to employ, and let me advise you very strongly to stick always to corrosive sublimate. You may use either the perchloride or the biniodide of mercury, and, in the form of compressed tablets, one can readily make a solution of the necessary strength. Personally I always use perchloride tablets, one of which, dissolved in an imperial pint of hot water, makes a solution of 1 in 1,000 strength. Here let me ask you to remember two things: first, that perchloride of mercury is far and away the best and most reliable antiseptic to use for the hands and for the patient's vulva; and, secondly, that 1 in 1,000 is the weakest solution you can trust for such disinfection. Do not believe anyone who tells you that some other antiseptic is equally safe for the protection of your patient, or that a 1 in 1,000 strength is unnecessarily strong. After a preliminary use of the perchloride solution for your hands and for the patient's external parts, you may conduct the labour, if you wish, with a solution of lysol (1 in 150 of water); but if you take my advice you will never omit to use perchloride in the first instance.

After the hands have been thoroughly washed, the soap is removed by rinsing in clean water; a towel should not be used. Then you proceed immediately to disinfect your hands in a basin of hot perchloride solution of 1 in 1,000 strength. Put a pledget of absorbent wool into the solution, and bathe the arms thoroughly, and again use a brush for the nails. Make this disinfection process last about three minutes.

The hands are now ready to make the vaginal examination, and they must not come in contact with anything until that time arrives; the next thing is to be equally careful about the disinfection of the vulvar skin and vaginal entrance.

In dispensary practice, where no nurse is present at the time of labour, I teach my students to carry out the following method, which, imperfect as it may appear to you, is, nevertheless, to be relied on, when carried out in conjunction with the after-treatment I recommend, to give you a complete immunity from septic infection. First, it is important to get the patient into the proper position in bed, so that the vulva may be efficiently cleansed, and the vaginal examination easily carried out. The left lateral position is the best, and the patient is placed well across the mattress, so that her back is nearly parallel with the top of the bed. You then carry the basin containing the perchloride solution over to the bedside, and, with a pledget of wool soaked in the antiseptic, swab the skin around the vulva. Then separate the labia and gently scrub the external organs as well. This being done, the patient may be safely examined, and, in my opinion, examined as often as you wish, if you continue to swab the parts from time to time, and keep your hands soaked in perchloride or lysol solution. I am not one of those who advocate one or two vaginal examinations only during the course of labour. I believe no increased risk is incurred from frequent and, if necessary, prolonged examinations, if due care is exercised in maintaining the antisepsis of the hands and external parts. You may use a lubricant if you wish, and it is pleasanter for the patient if you do so. If you use vaseline it is a good plan, after smearing it on the fingers, to immerse the hand in the perchloride solution before you examine.

So much, then, gentlemen, for the first part of your preventive treatment of puerperal infection—namely, keeping the genital tract free from pathogenic bacteria. But that is by no means all. You have next to take care that trouble does not arise from pieces of blood-clot, placenta, or membranes, which may be left in the uterus and vagina, and which, for some reason, do not remain aseptic until they are got rid of in the lochial discharge. Otherwise the temperature will rise in the puerperium.

This is why the second part of the treatment, namely,

Assisting and Maintaining the Involution of the Uterus,

is so important. Many practitioners, however, who are sufficiently careful of their hands and of the patient's vulva neglect this side of the question, and, by quite unnecessary interference, set things wrong when they would otherwise go right. I refer to the common practice of douching, not only immediately after labour, but also during the puerperium. Personally, gentlemen, during the last ten years of my practice, at any rate, no patient for whom I have been responsible has had her uterus washed out, no matter how complicated the labour may have been. The whole principle of the thing is wrong, and while a single washing out of the uterus, after having had one's hands or instruments inside, may do no actual harm, it cannot possibly do good in the way of killing organisms. Routine douching of the vagina, especially in the early days of the puerperium, may be a source of much harm, and it is only when the lochia become highly offensive that I sometimes advise it.

I wish now to tell you how you can best carry out the second part of the prophylactic treatment against sepsis; how you can guard against the infection of retained clot and membranes, and assist the uterus to expel these safely.

When the placenta leaves the uterus and is expelled out of the vagina, it sweeps the whole genital tract clean. It may be assumed that any pieces of clot and membrane left behind are aseptic, and that they will be safely got rid of if the uterine action is efficient. Hence, from this moment, it is most important to keep the tract closed, and thus avoid the infection of anything left inside. That is why I caution you so strongly against reopening the vagina with the nozzle of your douching apparatus. If you can assist the uterus to involute rapidly and well, and expel anything retained in its cavity, it must be admitted that there is greater safety for the lying-in woman. I have now ample evidence that this can be accomplished in a precise and definite manner.

The uterus can quite properly be compared to the heart; both are hollow muscular organs, and both are endowed with the power of contracting rhythmically. The uterus, like the heart, goes into a systole, and this is followed by a diastolic period. During its systole the uterus contracts; during diastole it is retracted. I want to remind you that the uterus begins to contract and relax from an early period of pregnancy—painless contractions; that it does so more actively during the period of labour, when the contractions become painful, and that it continues to contract during the puerperium. The systoles of the uterus are few and far between, but it is a perfectly well-established fact that certain drugs can definitely increase and prolong the contractions, and, just as in the case of the heart, improve the general tone of the organ. Digitalis is the principal remedy one uses for the heart, and it acts beautifully on the uterus during the puerperium, keeps it firmly contracted, and helps it to get rid of anything retained in its cavity.

Acting on this principle, gentlemen, I order a "post-partum" pill for every patient who comes under my care. The pill I usually prescribe contains pulv. digitalis, ½ gr.; ergotin and quin. sulph., of each a 1½ gr.; and ext. nucis vom., ¼ gr.; and, in most cases, it is given thrice daily for the first ten days of the puerperium. Sometimes it is given every four hours at first, if the uterus is larger than it should be, while in other cases one pill night and morning is sufficient. This pill was given from the first day of the puerperium, to nearly every one of the thousand patients who were attended from the New Town Dispensary during the five years that I acted as obstetric physician, and with most gratifying results as regards the puerperal morbidity. There was no maternal death from any cause, and no case developed septic complications which caused us more than quite temporary anxiety. When one has no death in over 1,000 cases of labour in this class of practice, there is, of course, some element of luck, because eclampsia and hæmorrhages may, at any time, claim a victim. And in this series of cases there was more than the average proportion of difficult and dangerous labours. But when one can keep such a large number of cases, treated under far from favourable conditions, practically free from septic infection, some credit must be given to the preventive measures adopted. None of the cases treated by this pill had secondary hæmorrhage, though frequently large pieces of membrane and bits of placenta were expelled from the uterus during the puerperium.

Should the temperature rise to 102° or more, and the pulse rate simultaneously quicken, as sometimes happens about the third or fourth day or later, I order, in addition to the pill, powders containing 5 grains of quinine with 10 grains of salicylate of soda. Such a powder is given every six hours for three or four doses, and this often leads to the temperature falling, and the puerperium goes on normally again. Certain objections have been raised to the use of this "post-partum" pill, but they are mainly theoretical, not practical. It has been said that when the temperature is raised in the puerperium, digitalis, by slowing the pulse, will mislead one into thinking that there is not much wrong. This is quite a mistaken idea, because, if fever is present, digitalis will have practically no effect in slowing the heart's action. It has also been said that the quinine and nux vomica are excreted by the mammary gland, and that the baby will refuse the breast because the milk tastes bitter. This is likewise a purely theoretical objection.

You may take it from me, gentlemen, that by the routine use of this pill in the puerperium you will greatly lessen your anxiety over the recovery of your cases. If you have been, in the first place, thoroughly careful in the details of your disinfection, you will be agreeably surprised to find even your most unlikely cases go through the puerperium without the development of any untoward symptom.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Thomas Sinclair, M.D, F.R.C.S. Eng., Professor of Surgery in Queen's College, and Surgeon to the Royal Victoria Hospital, Belfast. Subject: "A Case of Traumatic Epilepsy Treated by Operation."*

ORIGINAL PAPERS.

A PLEA FOR THE WIDER RECOGNITION OF BUDIN'S METHOD OF FEEDING INFANTS ON STERILISED WHOLE MILK.

By M. P. KERRAWALLA, M.D. (BRUX.), L.R.C.P. and S.E., L.M.R.C.P.I.

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AT the present time, when so much is written and said about the prevalent high rate of infant mortality, want of efficiency and safety of milk supply, I beg to urge a wider adoption of the plan of bringing up infants on sterilised whole milk as a contributing factor towards the amelioration of the above conditions. Apart from the deplorable tendency among the present-day mothers of trusting more and more to artificial feeding, under certain conditions breast feeding is impracticable, and in such cases the above method would go far towards lessening the disadvantages and evils of artificial feeding.

According to Dr. G. F. Still (*a*), 96 per cent. of the cases of infantile diarrhœa investigated by him at the Children's Hospital were hand-fed. He also points out that condensed milk is particularly dangerous, and the child who is taking it runs a special risk of summer diarrhœa. He found that of the fatal cases of diarrhœa, 25.8 per cent. had been fed upon condensed milk.

In the unfortunate absence of any proper State supervision of milk supply, the milk has to be rendered innocuous, but in a manner that does not prejudice its nutritive value.

Boiling, though it kills germs, alters the nutritive value of milk, and is therefore unsuitable for very young infants.

Pasteurisation requires a rather complicated apparatus, and if rapidly done, though it retards the growth of germs, it does not destroy them.

Sterilisation of milk is attained by surrounding the vessel containing milk with water which is raised to boiling point and kept so for 40 minutes. It is admirably achieved by means of any of the sterilisers on the market, notably that of Soxhlet, in which the quantity required for each feed is separately dealt with. But the method is capable of being carried out even without the aid of any special apparatus. The plan, as successfully tried by me in the case of my poorer patients, was to instruct the mother as to the great importance of cleanliness and procuring milk from a reliable source, and then advise her to put the milk required for each feed in a separate small glass bottle (or, if that was too troublesome, the quantity for 24 hours or part of it), and put this bottle immersed three-quarters in a saucepan of water, the water being subsequently raised to boiling point and kept so for 40 minutes.

The milk is slightly warmed before giving it to the infant, and no addition of sugar or cream is required.

The plan, as originally suggested by Professor Budin, of Paris, has been carried out by him and other Continental authorities for many years with gratifying results. In this country there exists a great prejudice against sterilisation, as it is thought to lead to scurvy; but Budin and other authorities who have reared a very large number of infants, have failed to record even a single case of scurvy resulting from the use of sterilised milk.

Professor Kenwood, in a paper (*b*) read before the

(*a*) MEDICAL PRESS AND CIRCULAR, August 28th, 1907.

(*b*) MEDICAL PRESS AND CIRCULAR, August 21st, 1907.

Section of State Medicine at the last annual meeting of the British Medical Association, makes the following remarks:—"In America, Denmark, and France, each with an extensive experience covering many years, the verdict is favourable to sterilised milk. Dr. Variot, whose experience is unique, since his feeding experiments at the "Goutte de Lait" at Belleville relate to over 3,000 healthy as well as unhealthy children who were closely observed by him for many months, has seen nothing of infantile scurvy resulting from the use of sterilised milk. The facts collected from the experience of other such institutions abroad, and from the Consultations des Nourrissons in France, are further testimony to the almost absolute harmlessness of sterilised milk. On all sides the general experience is that extremely little scurvy results from the use of sterilised milk, and the late Professor Budin, whose consultations are now established all over France, and were first started in 1892, wrote to me under date April 6th, 1906, that as the outcome of his wide experience he had not seen a single case of scurvy resulting from the use of sterilised milk."

By using the milk previously sterilised, Budin and other authorities claim that they never saw in their patients, rickets, eczema, abdominal distension, dyspepsia, tuberculosis, scurvy or diarrhœa. By sterilisation the milk itself is submitted to a temperature of about 180° F., which, though enough to destroy germs, does not lead to any detriment in its nutritive value.

As regards the use of cow's milk undiluted from birth, I cannot do better than quote the following from Dr. Maloni's translation of Budin's work, of which I have availed myself freely. Should cow's milk be given undiluted?

It is generally supposed to be harmful to infants, owing to the excess of casein it contains, compared with human milk. To counteract this defect, great quantities of water are usually added to the milk, the dilution varying with the age. But casein is not the sole constituent of milk. It also contains sugar, butter, and salts, all of which materially contribute to the value of milk as a food. Diluted cow's milk is generally deficient in these substances, and therefore forms but a poor substitute for a mother's milk. To obtain sufficient nourishment on this attenuated diet, infants are obliged to absorb great quantities of fluid, which causes them to pass a large amount of urine. They are almost always crying from hunger, whereas infants on undiluted milk wait contentedly for their next meal.

It is alleged that casein of cow's milk forms large clots in the stomach, and gives rise to digestive troubles. This is obviated if the milk is heated in a steriliser at a temperature of about 100° C.

"According to my experiments in vitro," says Chavane, "the clot of milk thus sterilised offers no resistance or sense of elasticity to the finger on pressure. It yields like a thick fluid, such as cream, and on microscopical examination, although the fat globules are not appreciably altered, the particles of casein are found to be smaller and more homogeneous. It differs from the fine clot of human milk. It is distinct from that obtained from asses' milk, but it is quite comparable with the latter as regards the size of the casein particles. Obviously this sterilisation below boiling point—*i.e.*, heating to 100° C.—modifies the casein so as to effect the state of sub-division of the clot, and also the molecular structure of the particles. This probably explains why milk thus sterilised is more easy to digest than either fresh or boiled milk.

Sterilisation is greatly simplified by the use of undiluted milk. It is a complicated process when dilution has first to be performed according to the infant's age. When the same milk is dispensed to infants of all ages, the mother's duties are made easy, and the work greatly facilitated."

Lazard says:—"Infants, who are, after all, the best test of the quality of the milk, support sterilised milk admirably. I recommend it undiluted. Experience has taught its great value, for not only is it easily tolerated by healthy infants, but it is also the best remedy for diarrhœa in certain cases, and has saved marasmic cases veritably from the jaws of death."

Just as all infants do not thrive even on breast feeding, so some infants during the first month or so will not thrive on whole milk. In such cases, and in the case of weaklings and premature babies, Budin gives the milk, not diluted, but peptonised. He recommends pepsin in the form of small scales, a small amount of which (a pinch to a salt-spoonful) is given in water before meals. In some cases the addition of water, one-fourth the bulk of milk, added before sterilisation will be found efficacious.

The number of feeds in 24 hours is the same as in the case of undiluted milk, although a slightly less amount is required. In every case it is best to be guided by the condition and progress of the infant. By this method the infant takes less fluid, which in itself is an advantage, puts on weight more rapidly, and by reason of its leaving a greater residue in the alimentary tract, ensures regular action of the bowels. I can bear out these facts by personal experience. The obvious advantages of a method which brings about freedom of milk from germs, and obviates the necessity of handling it for the purpose of dilution and addition of cream and sugar, will not fail to appeal to those who are conversant with the drawbacks as regards these points in the poorer classes of community where the nature of these articles hardly inspires confidence as to their quality or purity.

The plan has been successfully employed at the Rotunda Hospital, Dublin, by its present Master, Dr. Tweedy, who in a letter on the subject to me states that during the interval of feeds the infant should be given as much water as it can take.

Personally, I have found the administration of a teaspoonful of olive oil night and morning a great help. According to Holt, one gets scurvy in every form of feeding. It is obviously the poor quality of milk which gives rise to the disease, and therefore the risk of it is greater in diluted than in undiluted milk.

During my connection with the Brighton Lying-In Institution, I tried the method in several cases, and in every case it gave me entire satisfaction. Even the nurses and mothers who at first regarded the plan in the light of a novel experiment did not fail to be impressed with the progress and well-being of the infant.

I have selected the following two cases to illustrate some of the remarks I have made above:—

(*a*) *Baby D.*—Weight at birth, 7 lbs. It was fed from birth on sterilised whole cow's milk, with dr. 1 of olive oil night and morning:—

1st	week	fed on	oz. i	2	hourly	weight	at the	end of	week	7¼ lbs.
2nd	,,	,,	oz. ii	2	,,	,,	,,	,,		7¾ lbs.
3rd	,,	,,	oz. iii	2	,,	,,	,,	,,		8¼ lbs.
4th	,,	,,	oz. iv	2	,,	,,	,,	,,		8¾ lbs.
6th	,,	,,	oz. vi	3	,,	,,	,,	,,		9½ lbs.
12th	,,	,,	oz. xii	3	,,	,,	,,	,,		14 lbs.

The child never suffered from sickness, diarrhœa, or any other trouble.

(*b*) *Baby P.*—Premature 7½ months baby. Weight at birth, 6 lbs. It was brought for advice when six weeks old, being very restless and irritable; weighed 6 lbs., and was suffering from abdominal distention and sickness. On inquiry it was found that the mother was feeding it on condensed milk, because she said she could not afford cream to dilute cow's milk. She, however, consented to try feeding it on sterilised cow's milk (undiluted), as it needed no outlay for purchasing cream. At the end of a week's trial, the baby looked better in every way, slept well, and had gained a little in weight. For twelve subsequent weeks it gained weight at the rate of half a pound a week.

The ease with which the method can be carried out, coupled with the immediate and remote advantages it holds out over other methods, will not, I feel sure, fail to impress anyone on a trial of it.

HÆMORRHAGIC RASHES. (*a*)

By GEORGE PERNET.

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(Concluded from our last issue.)

An important group of toxic purpuric rashes due to drugs must now be touched upon [15]. A number of drugs have been from time to time accused in this way, the chief culprits being iodide of potassium, quinine, antipyrin, chloral, copaiba and mercury. In

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(*a*) A Paper read before the West London Medico-Chirur Society, 1907.

such instances the general condition of the patients has usually left something to be desired, either in the way of faulty renal elimination or cardiac disease, or the existence of other toxic conditions of organism at the time. Iodide of potassium as a toxic agent of this kind appears to head the list. Thus in a man with a purpuric eruption, it was found he had been taking iodide of potassium. He had a diastolic murmur and a cloud of albumin in the urine; moreover, there was some evidence of alcoholism. In a case of advanced nodular leprosy I had had under observation, and notwithstanding my warning that iodide of potassium should not be administered, the drug was ordered under the quite erroneous idea the case was one of syphilis after all; the result was a purpuric eruption about the legs. Lepers are specially susceptible to ordinary doses of potassium iodide, and this fact was made use of by Danielssen, of Bergen, as a test. In connection with this drug it should be borne in mind that it is the basis of advertised blood mixtures. Shepherd has recorded a case of purpuric eruption ending in gangrene, which was apparently caused by sodium salicylate [16]. Sandal-wood oil, administered under various names for gonorrhœa, has led to nephritis and cutaneous hæmorrhages, but it must be pointed out that the latter have occurred in the course of gonorrhœa apart from drugs, although doubts have been thrown on the gonococcus as the *fons et origo* [17].

In another group of cases, the acute pemphigus I have described as occurring in butchers, and arising from the infection of a wound, hæmorrhagic lesions and bullæ were noted in three of the eight cases I observed and collected [18]. In my case, Bulloch isolated a diplococcus corresponding to the microorganism described by Demme, a fact he has confirmed in another case very much like my own [19]. The complaint, a severe infection, is frequently fatal (seven out of nine in butchers).

The following hæmorrhagic vesicular eruption in an infant, one month old, was instructive. The skin condition commenced four days after birth, and when first seen the lesions, varying in size from a pin-head to a pea, were scattered about the body and limbs, including the soles and palms, but the child was well nourished and there was no evidence of syphilis. The eruption was totally different to that observed in congenital syphilis. At the *post mortem* a few days after, the right pleural cavity was found to be full of pus, demonstrating the toxic origin of the rash.

In herpes zoster some of the vesicles may be hæmorrhagic, evidence of the severity of the attack, and mixed up with the vesicular rash hæmorrhagic punctate groups without vesiculation may be present. In hæmophilics, cutaneous hæmorrhages may occur either spontaneously or after slight injuries. As you know, bleeders are generally of the male sex, though the "diathesis" is handed down mainly in the female line. Were it otherwise the females would run great risks at the establishment of the menses and also at parturition, but here again hæmophilia appears to be less severe in women when they are affected. Such hæmophilic hæmorrhages may be of medico-legal interest. In a case mentioned by Poore, the body of a boy, who had died after a flogging, was exhumed and numerous subcutaneous hæmorrhages were found. This was in 1856, when flogging and violent repressive measures were in fashion, the schoolmaster getting a long term of penal servitude. The case was probably an instance of hæmophilia [20].

In this connection I would call your attention to the importance of ecchymoses about the genitalia, breasts, face, lips, arms and legs of women and girls in cases of rape or attempted rape. Hoffman has pointed out that in some women there are pigmented areas at the upper inner parts of the thighs, that look very like ecchymoses or bruises eight or ten days old [21]. In investigating such cases, the characteristic signs of cutaneous and subcutaneous hæmorrhages must be borne in mind. It is also essential not to lose sight of the possibility of simulation. Fallot records the case of a girl who pretended she had been violated in a wood by some unknown man; in proof she showed some bluish spots on the internal surface of the thighs and posterior part of the back. The spots were round with a broken border and more discoloured at the edges than in the centre, two points suggestive of simulation, I may say. It was found the girl had been supplied with some thick blackish liquid which she had applied [22]. In the old days simulation of ecchymoses appears to have been frequent in the services. When produced by dry cupping or suction, the shape must be taken into account.

Again, spontaneous ecchymoses and skin hæmorrhages are stated to occur in the hysterical, and indeed to have been produced by suggestion. But although cases of this kind have been recorded by sceptical observers, it is well to keep an open mind on the subject. Such manifestations as bloody sweat and bleeding stigmata were at one time held to be a proof of possession by incubi, or as in the well-known Louise Lateau to be miraculous [23]. As to hæmorrhages under the nails apart from injuries, I may merely mention that they may accompany cutaneous hæmorrhages, or occur alone, as in hemiplegia, for instance [24].

I must now deal rapidly with the histology and mechanism of cutaneous hæmorrhages, together with their pathogenesis and ætiology [25]. On *à priori* grounds, diapedesis appeared at first to explain everything, but microscopical investigation showed this view applied to a few cases only, in the majority rupture of the vessels being present. On the other hand, Darier points out that almost all the vessels in purpura offer a remarkable integrity of aspect [26]. I would remind you of the two vascular networks of the skin, one superficial just below the papillæ of the skin and supplying the papillæ with capillaries (cutis vasculosa), the other subcutaneous, connected up with the former by vessels passing through the thickness of the cutis. According to Unna it is in connection with the deeper network that hæmorrhages most usually take place apparently, more rarely extending to the papillary network; more rarely still is hæmorrhage limited to the latter and the epidermis. The weak spot appears to be the point of entry of the hypodermic vessels in the cutis proper. In the microscopical investigation of hæmorrhages it is necessary to cut horizontal sections of the skin to get a clearer idea of the state of affairs, a method which enabled Unna to demonstrate more readily the seat of rupture in the vessels.

In the first place hæmorrhages may occur as a result of negative pressure, as in cupping. Here I should like to mention that, according to Leduc, the osmotic pressure of the blood is enormous, seven and a half atmospheres [27]. Another explanation was thrombosis, but the fact is that venous thrombosis may be present, with paresis of the arteries, as in erysipelas, without hæmorrhage necessarily occurring.

Again, bacterial emboli may be present in the capillaries without consecutive thrombosis, although the latter may occur. But it is beyond doubt that in purpuric eruptions bacillary emboli have been found.

In venous stagnation of the legs, ecchymoses and subsequent pigmentation may occur. I have seen ulcerations in varicose legs become distinctly hæmorrhagic, with a tendency to sloughing. But neither stagnation nor hypostatic hyperæmia in the veins of the leg leads necessarily to hæmorrhages in the skin. I need scarcely insist on the *post mortem* hypostatic discolouration and lividities sometimes taken for bruises by juries; they are not extravasations.

Naturally a point of importance in the subject we are considering is the condition of the vessel walls. A variety of changes have been put forward to explain hæmorrhages, such as molecular destruction, hyaline degeneration and so forth, to say nothing of defective formation. Again, it was natural to think of the toxic effects of poisons, bacterial and otherwise, on the walls of the cutaneous vessels. And here I should like to call your attention to the experiments which have been made with snake venom. Snake-bites are well known to produce hæmorrhages very rapidly. Snake-venom is a complex body, and its hæmolytic properties need not be insisted on here. But in addition to this property, Flexner and Noguchi have apparently shown that these hæmorrhages are due to the presence in venom of a cytotoxin, which has the power of dissolving endothelial cells, in other words an endotheliolysin [28]. This appears to me all the more important when taken in connection with the fact that the osmotic pressure of the blood is equivalent to seven and a half atmospheres, according to Leduc, a pressure which does not assert itself by morbid changes in ordinary circumstances. But when the vascular walls are damaged, the blood itself altered in various ways, and the vascular innervation interfered with, it is no wonder that rhexis should occur. I put this forward merely as a hypothesis, for I know but too well how many of our explanations need explaining. Things are not so simple as they seem, for in addition to the factors I have just alluded to, the cells of the organism are extremely sensitive to changes in osmotic pressure; thus in concentrated chloride of sodium solutions, the blood corpuscles lose their water and shrivel; in water and very dilute salt solutions they swell up and burst. It has been shown that all bodies are more or less radio-active, and moreover, it would appear that hæmoglobin acts like a catalytic ferment [29]. Hæmoglobin contains iron, which varies in quantity in different species. And here I would suggest that inorganic iron, which empirically sometimes gives good results in hæmorrhagic rashes, may act in a catalytic way, for according to Bunge, inorganic preparations of iron do not appear to be assimilated by the organism [30]. May not arsenic act in a similar manner, for arsenic undoubtedly does appear to act beneficially, in some purpuric conditions at any rate.

As far as the blood is concerned, the coagulability and the freezing-point (cryoscopy) are also elements in the problem, a very complex one indeed, as you will perceive, which will require much labour to elucidate, or even to approach elucidation.

Hæmolysis *in vitro*, at any rate, occurs as you know in a variety of circumstances, apart from snake-venom, as, for instance, by the addition of water, glucosides, foreign serum, and so forth [31]. On the other hand, Carnot and Desflandres have shown that if a rabbit be bled the blood is rapidly regenerated, but if during this regenerative process the serum be injected into a normal rabbit, a considerable increase of red corpuscles takes place in the latter, the number rising from about five millions, to eight, nine, and twelve millions on the three following days respectively. This regeneration appears to be due to a chemical substance which is destroyed at 55° and exists in small quantities under normal conditions, but in larger quantities after bleeding. This substance is present not only in the serum but also in the bone marrow [32]. Whether anything can be made out of this in the treatment of hæmorrhagic rashes the future will show.

As regards hæmolysis, may it not be that owing to the disintegration of the complex molecule of the hæmoglobin, a liberation of energy takes place with a bombardment of the walls of the blood-vessels by ions, electrons and other radiations? Leduc found that the experimental introduction of ions of calcic alkaline earths into the skin of animals produced blackish and ecchymotic lesions the next day, ultimately leading to ulceration with indurated base [33].

As an illustration of the severe attack on the blood in purpuric eruptions, I may mention a case of streptococcal morbus maculosus recorded by Heubner, a girl aged 9½, in whom the number of erythrocytes sank in a few days from 4,400,000 to 1,200,000, the white corpuscles numbering 9-10,000. Microscopically, there was neither poikilocytosis nor megaloblasts, but numerous normoblasts with pyknotic nuclei were present. The lymphocytes compared with the polynuclears were as 90 to 10. At the necropsy the bone-marrow was found to be raspberry-coloured and jelly-like, and almost entirely made up of mononuclear cells, with homogeneous protoplasm. Short streptococcal chains were also present between the cells. A pure streptococcal culture was obtained from the spleen [34]. The state of the bone-marrow and spleen have not, as far as I know, been systematically investigated in fatal cases of purpuric eruptions.

I have already referred to various micro-organisms found in cases of cutaneous hæmorrhages. But Kolb [35] and Finkelstein [36] have described what they consider to be the specific bacillus of idiopathic purpura, a bacillus which proved pathogenic when inoculated in animals. With regard to the pneumococcus, Klein has described the instructive case of a nurse who developed a purpuric rash over the lower part of the abdomen and inner part of the thighs. This rash was diagnosed clinically as hæmorrhagic variola, for the patient had had some intercourse with nurses who had been to the small-pox ships. The patient died. Sections of skin revealed numerous pneumococci and hæmorrhages in the cutis, but there was a subepidermal zone free from both, the epidermis being normal [37]. The "bathing-drawers" rash was certainly in favour of variola, but how account for the pneumococci? In a section of true hæmorrhagic small-pox figured by Klein the hæmorrhages were just below the epidermis, the latter showing cleavage on the way to vesiculation. To complicate matters further, Klein found in the nurse case micro-organisms that stained in a bi-polar manner, not dissimilar to those of *Bacillus pestis*, in addition to the diplococcus pneumoniæ.

I need not remind you of the fact that in plague cutaneous hæmorrhages may occur, especially in some epidemics.

I have referred to the influence of the nervous system, which is well exemplified in herpes zoster with hæmorrhages, depending as that eruptive condition does on a lesion of the posterior ganglion. When the toxic effects on the nervous system are intense, as is the case in severe variolous infection, a purpuric rash with a rapidly fatal *dénouement* may sometimes lead to variola being overlooked. Experimentally the destruction of the abdominal sympathetic ganglion in the frog has been followed by hæmorrhages in the lower limbs. At the necropsy in a case of purpura hæmorrhagica, Hale White [38] found acute inflammation of the semi-lunar and cervical ganglia, but whether there was here a relation of cause and effect or whether both morbid conditions in the skin and nerves arose from the same cause is a point that necessarily suggests itself. Schwimmer was strongly of opinion that purpura was trophoneurotic in origin. But the facts I have brought forward will not allow of our agreeing with such a dogmatic attitude, especially as physiologists tell us that no certain proof of the existence of specific trophic nerves has been given [39]. In neuralgia, hæmorrhages have been observed at the point of greatest pain, and this repeatedly in successive attacks. Similarly injuries to nerves and nerve involvement in malaria, etc., have led to hæmorrhages. When the innervation of a limb is below par, as in old hemiplegia, a rash may be more marked in it than in the sound one. Thus in a man with an eruption on the legs, the old hemiplegic limb presented many bullous lesions, whereas in the sound one the lesions were papulo-vesicular and not numerous. This was not a purpuric case, it is true, but I mention it as an illustration merely. I have already alluded to subungual hæmorrhages in hemiplegia. This consideration of the nervous system leads me now to refer to the suprarenal glands, and also adrenalin, the hæmostatic properties of which I need not insist on, for according to Balfour, the suprarenals have in the fœtus a twofold origin, the cortex being derived from the mesoblastic tissue, while the medulla is formed by a direct outgrowth from the sympathetic system, consisting at first of an aggregation of neuroblasts. In some animals, *e.g.*, teleostean fishes, the two parts of the gland remain separate throughout life, but in the higher vertebrates the sympathetic outgrowth becomes surrounded by the cortex, and the cells rapidly lose all traces of resemblance to a nerve cell. But the medullary portion is genetically part of the sympathetic system, and its specific secretion, adrenalin, has an action which is apparently confined to that system [40]. The excision of the suprarenal bodies causes a profound fall of blood-pressure; whereas injection of adrenalin increases blood-pressure [41]. It has been suggested, on insufficient grounds it appears to me, that because hæmorrhages into the suprarenal glands were found in some cases of purpura evidently streptococcal in origin, that the suprarenal condition had led to the hæmorrhages in the skin. The explanation appears to me pretty obvious, viz., that both the visceral and cutaneous hæmorrhages depended on the streptococcal infection. Suprarenal hæmorrhages have been found where there was no involvement of the skin in the way of purpuric manifestations. Moreover, in Addison's disease I do not remember ever having seen cutaneous hæmorrhages, nor have I heard or read of such occurring in that disease, nor would one expect anything of the kind on the *à priori* ground that lowering of the blood-pressure is the result of excision of the glands. But in dealing with a subject that requires so much elucidation, it is advisable to keep one's mind open on these points. The changes in the circulation which occur at the menstrual period have been considered to play a part in ecchymotic and purpuric conditions. Danlos [42] and others have published cases of cutaneous hæmorrhages apparently connected with the catemenia. I would here point out that, according to the recent researches of Marshall and Jolly, the changes in the uterus which determine menstruation are due not to ovulation but to an internal secretion from the ovary [43], so that the question arises as to whether the rashes I have referred to, which appear to be connected with menstruation, may not be connected in some way or other with this internal secretion. Howbeit, the extract from another gland, the thyroid, has apparently given rise to rashes with hæmorrhagic tendency. When purpuric rashes occur in pregnancy, the idea of a toxæmia of course suggests itself.

Reviewing what has been stated as to causation and pathogenesis, it is unnecessary for me to call attention once more to the complexity of the problem, so that when one is face to face with a hæmorrhagic rash, treatment must be to a great extent empirical. The first indication, especially where there is any severity of the onslaught, or the condition is complicated by other hæmorrhages, is posture, that is, the horizontal position. Bed alone will do a great deal. As I have already told you it is important to be on one's guard, and the general impression made by the patient must be borne in mind. Cutaneous hæmorrhages may commence in a mild way, but ultimately, perhaps suddenly, more serious symptoms may develop.

The *primæ viæ* are frequently at fault in the erythema purpuricum conditions. Intestinal auto-intoxications must be dealt with by means of saline aperients, etc., but I need scarcely insist, after what I have said, on the need for caution in this direction.

The buccal cavity, especially the teeth, should always receive attention, even when the hæmorrhagic rash does not appear to be directly traceable to the bad condition of the mouth.

In the ordinary run of cases, arsenic and perchloride of iron sometimes answer well. In more severe cases turpentine may prove very useful, but it requires to be administered with caution: ♏x. to ♏xxx. of the oil of turpentine (commencing with the smaller dose and gradually increasing) suspended in mucilage in mixture three times a day immediately after meals, the last dose being taken not later than 6 p.m. Plenty of barley water should be drunk during the treatment. These precautions are necessary to prevent kidney trouble. The urine, it goes without saying, should be examined regularly.

Since Wright's work on the coagulability of the blood and the administration of calcium chloride, this drug has been used, as also lactate of calcium. In some cases I have found calcium chloride of use, but it requires to be pushed before any effect is obtained. When testing a drug, too, with a patient in bed, it is important not to commence its administration at once, but only after some days, to avoid giving credit to the drug really due to the horizonal position of rest. Various other drugs have been extolled, but here the *post hoc, propter hoc* fallacy needs to be warily watched. Perchloride of mercury and gelatine injections have been recommended, but with regard to the latter subsequent experience has shown that complications might arise. In cutaneous hæmorrhages depending on general conditions, such as albuminuria, liver disease, enteric, etc., treatment must be directed to them. The care of such patients may become a difficult matter.

In streptococcal infections antistreptococcic serum would certainly be indicated. And in this connection I would mention rectal injections of polyvalent serum, which answered so well in two cases of severe purpuric rash complicated by other hæmorrhages under Fenwick and Parkinson. In one of these patients the injection synchronised with rapid cessation of the hæmorrhage at a time when death seemed to be only a question of a few hours, so there seems no reason to doubt its efficacy in that case [44].

In a general way, attempts should be made to keep up the patient's strength by the administration of real foods; this is important in bad cases. By real foods I mean raw white of egg, for instance, and not meat extracts. The latter, as foods, whatever they may be as stimulants, always remind me of the man who got a stone when he asked for bread. There is not much to expect from alcoholic stimulants, which are likely to do more harm than good in hæmorrhagic conditions, and are pretty certain to hurry a patient down hill when they arise in the course of infections.

As to adrenalin, its value or otherwise is a point which does not appear to have been decided. But some observers have spoken well of it as well as of ergot. Bandaging the legs carefully may be of use, especially in out-patient cases of hospital practice.

Altogether treatment must depend on the individual case to be dealt with, its merits, surroundings and circumstances. There is no royal road and no specific.

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THE

PREVENTION OF TUBERCULOSIS,

WITH SPECIAL REFERENCE TO

TUBERCULOSIS IN IRELAND. (a)

By ROBERT E. MATHESON, LL.D.,

Registrar-General for Ireland.

The question of the prevention and cure of tuberculosis has for some years occupied grave attention in all civilised States in the world.

An International Congress on the subject was held in London in 1901, and a further Congress in Paris in 1905, both of which I attended in my official capacity as a delegate from the Irish Government. The Paris Congress was particularly interesting and helpful, and the French Government spared no pains or expense to make it a really useful conference. It was held in the Palais des Beaux Arts in the Champs Elysées, a magnificent building, eminently suited to the purpose. The Congress was opened by the late President of the French Republic, Monsieur Loubet, and in the opening ceremony delegates from many countries took part. The Museum was a source of practical instruction. On entering was a Bureau of the Prefect of the Seine, where many excellent notices were exhibited warning the public as to the deadly nature of the disease, and the means of preventing infection. Further on was shown a bedroom in an hotel, ill lit and ill ventilated, and side by side with it was presented a model of an hotel bedroom, well lit and well ventilated, arranged by the Touring Club of France. Then a model of a domestic servant's room in a Paris house was contrasted with the model of a cell in the French Prison at Fresnes. Further on there was an ideal sanatorium—a model room in the Lariboisiere Hospital. The Museum contained also many beautiful pathological specimens, and portions of the human body and the bodies of animals affected by the disease in its various forms. There were also many statistical charts, exhibiting the status of the disease in the various countries, and models and designs of sanatoria and of sanitary appliances having special bearing on the subject.

These Congresses have undoubtedly done great service in bringing together those interested in combating the ravages of the disease in the various countries, enabling them to compare notes and discuss together the many practical problems which arise in dealing with the disease.

I cannot, perhaps, open my address this evening in a better way than by showing my audience a copy of the badge issued to delegates and members of the Paris International Congress, 1905. The figure on the badge represents a poor victim of tuberculous disease stretching out her hand and imploring help in her desperate condition. The author of this beautiful design touched a chord of pity in every heart, and lent a pathos to all the deliberations of the Congress. Substituting a fair Irish colleen for her unhappy French sister, we have a picture of what might be represented in many an Irish home, where the flower of youth and beauty are year by year being carried off by this awful scourge.

The august lady, our gracious Vice-Reine, who has organised this Tuberculosis Exhibition, and to whom Ireland is under so deep an obligation for her unceasing activity in promoting every good work tending to the improvement of the country and the amelioration of the condition of its inhabitants, has had the same humanitarian object before her as was before the Paris Congress—viz., how this dreadful disease, which is so fatal in Ireland, can be successfully combated.

In furtherance of this object the first step is, I think, to ascertain clearly how we stand with regard to it, and the information collected and tabulated by my department affords a solid basis on which all administrative action must rest.

Though the registration of deaths only came into operation in 1864, we have statistics of the deaths from pulmonary tuberculosis back as far as 1831. In the Report of the Census Commissioners for 1841 it appears that the number of deaths from consumption, or pulmonary tuberculosis, from June, 1831, to June, 1841, was 135,590. The Commissioners remark that this malady is "by far the most fatal affection to which the inhabitants of this country are subject." According to the Census Commissioners of 1851, the number of deaths from consumption between June, 1841, and March, 1851, was 153,098. The census reports of 1861 record 130,739 deaths from pulmonary tuberculosis between March, 1851, and April, 1861. In the period between April, 1861, and January, 1864, when the registration of deaths commenced, it appears from the report of the Census Commissioners of 1871 that 26,267 deaths occurred from consumption. These figures make the appalling total of 445,694 deaths from pulmonary consumption from June, 1831, to January, 1864, and, having regard to the manner in which the information was obtained, there is no doubt that this total is considerably under the truth.

On January 1st, 1864, the Act for the Registration of Deaths in Ireland came into operation, that for England having been in operation since 1837, and that for Scotland since 1855.

Tuberculosis in England, Scotland, and Ireland, 1864—1906.

In my annual report for 1906 is a chart showing the statistical history of tuberculosis in the three countries from 1864 to 1906. From this it appears that while in 1864 Ireland stood lowest of the three, with a rate of 2.4 per 1,000 living, the rate for England being 3.3, and that for Scotland 3.6, in 1905 Ireland occupied the unhappy position of being the highest with a rate of 2.7, Scotland being next with 2.1, and England lowest with a rate of 1.6. The attention which has been paid to sanitation in the sister countries has doubtless largely conduced to this result, and the chart, an enlarged copy of which is included in my exhibit, loudly calls for a sanitary campaign in this country with a view of reducing our death-rate from this dreadful disease.

But it is not only with respect to the other divisions of the United Kingdom that we are in so disadvantageous a position, but Ireland occupies a lamentably high position as regards death-rate from this malady when compared with other countries. The last annual report of my colleague the Registrar-General for England gives an interesting table showing the death-rates from consumption in various British possessions and foreign states. This table, an enlargement of which is in the Exhibition, deals with pulmonary consumption only, and discloses the sad fact that in the world's records our country stands fourth highest, being only exceeded by Hungary, Austria, and Servia.

Having thus reviewed our position as compared with other States, I now come to consider in detail the status of the disease in this country. In my last annual report I presented a diagram showing the mortality from 22 of the principal causes of death in Ireland in the year 1906. From this diagram (an enlarged copy of which will be found in the Exhibition) it appears that the mortality from tuberculous disease far exceeds that from any other causes of death. Out of a total of 74,427 deaths registered in Ireland in 1906, no fewer than 11,756, or 15.8 per cent., were due to this disease, which is in a great degree preventable. But it is not only that so large a number of our fellow-countrymen and women have been carried off by this scourge but that the mortality is greatest in those ages which ought to form the backbone of our population.

(a) Being a Lecture delivered at the Tuberculosis Exhibition held in Dublin in October, 1907.

My exhibit includes a table showing by sexes and age periods the number of deaths from tuberculosis registered in Ireland in 1906, with the rate per 1,000 living at each age period. This table shows the highest number of victims, and the highest rate per 1,000 living at each age period appear in the period of life from 15 to 45; the age period 15-20 claimed 1,355 victims, or 2.91; the age period 20-25, 1,660, or 3.80; the age group 25-35, 2,821, or 4.37; and that of 35 and under 45, 1,717 persons, or 3.61 per 1,000 living at those ages.

In my annual report for 1905, I gave a diagram showing the proportion of deaths at each age period in England, Scotland, and Ireland in the year 1903. An enlargement of this diagram will be found in my exhibit. A comparison of the ages of the persons who died from tuberculosis in England and Scotland with those who were carried off by that scourge in Ireland, as shown in the diagram, reveals the further fact that the mortality rate from tuberculosis to the number per 1,000 living at those ages in Ireland at the ages 10-15, 15-20, 20-25, 25-35, and 35-45, is enormously higher than it is in England or Scotland.

The explanation of this may, I think, be looked for under two causes:—(1) The emigration from the country for so many years, which has removed the able and healthy, and thus left amongst the residue an increased percentage of the enfeebled and persons less able to withstand the attacks of disease.

(2) The deaths of emigrants who have contracted the disease in other countries, chiefly in America, and have returned to die here. These persons, some of whom were not enumerated in the population, but whose deaths are included in the death-rates shown in the diagram, abnormally swell the death-roll.

(In support of this view Dr. Matheson quoted the reports from several Registrars of Deaths, showing that the death returns were largely increased by returned Irish-Americans, who had been sent back from America by their medical advisers suffering from phthisis. This practice, of course, assists in the spreading of the disease among the poor people at home.)

Though infant mortality in Ireland, as a whole, is much lower than in England and Scotland, the question of tuberculosis amongst infants is an important one, specially in our urban districts. In my annual report for 1906 I presented a diagram showing the infant mortality from 14 principal causes during that year, from which it appears that the infantile victims of tuberculous disease numbered about 400, being equal to a rate of 3.85 per 1,000 births registered. A similar diagram (enlarged) for the year 1905 will be found in my exhibit.

The next point with which I propose to deal is the relative percentage of mortality from the principal forms of tuberculous disease, and their distribution under each sex. This is shown in a diagram contained in my annual report for 1904, an enlargement of which, for the year 1906, is included in the Exhibition. It appears that in 1906 the deaths from phthisis, or pulmonary consumption, were 76.0 per cent. of the total deaths from tuberculosis. The deaths from tuberculous meningitis were 6.8 per cent.; from tuberculous peritonitis and tabes mesenterica 3.9 per cent.; from general tuberculosis 7.3 per cent., and from other forms of the disease 6.0 per cent.

The deaths among males from phthisis were slightly less than those among females, the former being 75.8, and the latter 76.2. The percentage of deaths from tuberculous meningitis was the same for both sexes, viz., 6.8 per cent. The percentage of female deaths from tuberculous peritonitis and tabes mesenterica was in excess of the male percentage, the rate for females being 4.2, and for males 3.7 of the total.

The seasonal mortality from tuberculosis in Ireland is shown in a diagram contained in my annual report for the year 1904. From that diagram it appears that of the total deaths from tuberculosis, 29.1 per cent. were registered in the June quarter, 27.3 per cent. were registered in the March quarter, 22.3 per cent. were registered in September quarter, and 21.3 per cent. in the December quarter of the year.

In my annual report for 1905 is a map showing the death-rate from all forms of tuberculous disease in 1905 for each Poor Law Union (of which there are 159)—the deaths in lunatic asylums and certain institutions being assigned to the Union to which the deceased belonged. An enlarged copy of this map is suspended in the exhibition. From it it appears that in two unions—viz., Lisnaskea, in the County Fermanagh, and Tulla, in the County of Clare—the rate did not exceed 1.0 per 1,000; that in 59 unions the death-rate from tuberculous disease ranged from 1.0 to 2.0 per 1,000 of the respective populations; that in 68 unions the mortality exceeded 2.0 per 1,000, and was under 2.7 per 1,000, which was the average death-rate for all forms of tuberculous disease for Ireland in 1905. That in 11 unions—viz., Antrim, Dingle, Dundalk, Enniscorthy, Larne, Limerick, Listowel, Lurgan, Middleton, Naas, and Rathdrum, the rate exceeded 2.7, but was under 3.0 per 1,000 of the respective populations.

That in 16 of the Poor Law Unions of Ireland—viz., in Banbridge, Bandon, Belfast, Carrick-on-Suir, Castlederg, Clonakilty, Downpatrick, Kinsale, Lisburn, Londonderry, Mallow, Newtownards, Skull, Strabane, Tullamore, and Waterford the rate ranged between 3.0 and 4.0 per 1,000. Finally, that in three Unions the rate exceeded 4.0 per 1,000. In North Dublin Union the highest death-rate from all forms of tuberculous disease was recorded, being 4.76 per 1,000; in Cork Union the rate for the year was 4.53 per 1,000, and in Dublin South Union it was 4.38.

There are not materials for preparing statistics of the mortality from tuberculosis for the whole country by occupations or social positions, but a table will be found in the annual summary of my weekly returns for last year showing the occupations or social position of the persons whose deaths were registered in the Dublin registration area as having died from tuberculous disease during the year 1906. A large table dealing with this subject is included in my exhibit. From this table it appears that of the total deaths, 1,694, representing a rate of 4.5 per 1,000, 6 only belong to the clerical, medical, legal, and other professions, naval and military officers and heads of public departments; that amongst the merchants and manufacturers of the higher class there was only one death; that amongst persons of rank and property (not otherwise described) there were only 4 deaths. In all, amongst the professional and independent classes there were only 11 deaths out of the total of 1,694.

From the middle classes 243 deaths were registered as follows:—11 from the general body of officials, Civil Service, banking, etc.; 49 from traders (excepting petty shopkeepers), business managers, etc.; 120 deaths of clerks and commercial assistants, and 63 deaths of householders in second-class localities, not included in above.

The deaths from tuberculosis among the artisan class and petty shopkeepers numbered 391, and comprise the deaths of 26 working engineers, engravers, printers, watchmakers or jewellers; 115 persons engaged in the building and furnishing trades; 84 in the clothing trades; 127 in other callings ranking with trades, and 20 petty shopkeepers.

In the general service class, of a total of 635 deaths, 27 were employed in the army, police, postal delivery, or prison services; 66 were those of domestic servants; 58 of coach and car-drivers, and vanmen, and 484 were described as hawkers, porters, or labourers. In addition to this, the deaths of 414 persons who were inmates of the workhouses occurred from tuberculous disease. Comparing the mortality in the first four classes, excluding Class V., workhouse inmates, we find that in the professional or independent class the rate was .63, in the middle class it was 2.79, amongst the artisan and petty shopkeepers it was 3.54, and in the general service class it was 4.12. These figures show that amongst the classes which are better housed, clothed, and fed, the mortality from this disease is much less than amongst those who have not the same advantages as regards housing, clothing, and diet, and whose callings expose them more to the severity of the weather than those more affluent in their circumstances.

Causes Favouring the Spread of the Disease.

I now come to consider the causes favouring tuberculosis, and I may mention three principal factors contributing to the spread of the disease:—

1. *Insanitary Houses and Surroundings.*—This is undoubtedly a very prominent cause in disseminating the germs of the malady. The notes on the sanitary condition of their districts, which are supplied to me each quarter by the Registrars, contain many references to this. The Registrar for Cloyne District (Middleton Union) remarks:—"I attribute 40 per cent. of the cases of illness amongst my dispensary patients to overcrowding and the filthy condition of the dwellings, the breathing and re-breathing of vitiated air causing a form of anæmia, accompanied with great debility, lowering the germicidal powers of their tissues, making them easy victims to tuberculous disease." The Registrar for Waterford No. 1 Urban District reports:—"The sanitary conditions in many parts of the district are bad—there are many houses having objectionable surroundings. The housing is in places deficient in air space, light, and ventilation. Tuberculosis is prevalent—it accounts for about 28 per cent. of the deaths." The Registrar for Holywell No. 2 District (Enniskillen Union) states:—"Tuberculosis is on the increase, and, I fear, will continue to be so until more stringent measures are taken to compel the people to pay more attention to the cleanliness of their houses and their surroundings, and particularly to the principle of ventilation and sunlight."

In connection with the influence exercised by insanitary surroundings in promoting tuberculosis, it is interesting to note the low death-rate from tuberculosis which prevails in our Irish prisons, which is doubtless due, in a large measure, to the care exercised by the Prisons Board in regulating the sanitary condition of the cells in which the prisoners are confined, and controlling their dietary. Her Excellency has been presented by Mr. James S. Gibbons, C.B., Chairman of the Prisons Board, with a series of photographs, showing the various descriptions of cells in the Irish prisons, which will be found in the Tuberculosis Exhibition.

2. *Intemperance.*—A further cause which operates more especially in urban districts is intemperance. In addition to the enfeebling of the constitution from over-indulgence in strong drink, the money spent thereon is frequently taken from that required to provide food and clothing for the children, who are thus rendered less able to withstand the attacks of disease.

3. *Neglect of Precautions against Infection.*—A third powerful agent is the practice which largely prevails in this country of living with consumptive patients without any precautions against infection—the result being that one sufferer is liable to infect the whole family. Nothing is more commonly met with than to find a poor consumptive living in a cabin with brothers and sisters, sharing their meals, and frequently sleeping with other members of the family, without the slightest regard to disinfection, and when remonstrated with the answer is, "Sure, it is only a decline." Several other causes might be mentioned, but these will suffice for my purpose this evening.

Remedial Measures.

We now pass to the remedial measures which come within our power to adopt, and these also may be considered under three heads.

1. *The Improvement in the Dwellings of the Working Classes.*—I am glad to say that much has been done in this direction. Those who remember the dreadful cellar dwellings which were to be found in Dublin thirty years ago will feel grateful to our distinguished Medical Officer of Health, Sir Charles Cameron, C.B., for his unceasing exertions to better the housing of the working classes. It is hardly necessary to refer to the deep obligation which the inhabitants of Dublin owe to Viscount Iveagh, K.P., through whose princely munificence large unhealthy areas have been cleared and sanitary dwellings erected. Much, however, still remains to be done, not only in Dublin, but throughout the country generally, if we are to have the terrible tuberculosis death-rate reduced.

2. *Dispensaries, Sanatoria, and Hospitals.*—The second way which is open to us to limit the ravages of the white scourge which paces our land is by the establishment of special dispensaries, sanatoria, and hospitals for the treatment of the disease. As this particular province of the subject will be dealt with by some of my co-lecturers who are professional experts, I need only allude to it here. In addition to the value of sanatoria and special hospitals for the cure of the disease, there can be no doubt that these institutions effect three other great objects:—(1) The alleviation of the symptoms of the poor sufferers, and (2) the withdrawal of the patients, at least temporarily, from their surroundings, in which in all probability they have been infecting others, and (3) the education of the patients and their friends as to the necessary precautions.

3. *Administrative and Educational Measures.*—A third preventive lies in administrative and educational measures. Pulmonary tuberculosis should be made by statute a compulsorily notifiable disease. A resolution to this effect was passed at the special meeting of the Consultative Committee of the Exhibition held on the 12th October. Children at school should be made liable to periodical inspection, so as to have the disease detected in its earlier stages, and hygiene should be taught everywhere in our schools. It is pleasing to note that the Board of National Education have taken this matter in hand, and that in their Programme of Instruction for National Schools, which came into operation on 1st July, 1906, they have directed that simple lessons on health and habits should be given to the scholars.

In bringing this lecture to a close, I desire most earnestly to impress on my hearers the responsibility which rests on the members of the community individually to do their utmost to aid in the efforts which are being made by Her Excellency the Countess of Aberdeen and the Women's National Health Association, as well as by other societies, to awaken the people generally to a sense of their danger. It is my firm belief that if our countrymen and countrywomen were really aroused to the gravity of the situation, their common sense, and intelligence would make them able allies in this great conflict, and that we should soon have to congratulate ourselves on the fact that the excessive mortality from tuberculosis, which is a present disgrace to Ireland, was a thing of the past.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Malignant Disease of the Œsophagus.—Gastrostomy.—Mr. T. P. Legg operated on a man, æt. 61, who had suffered from increasing difficulty in swallowing since the beginning of this year. During the last two or three months he had been able to take nothing but soft solids, and had developed a cough and hoarseness. He had become steadily weaker and emaciated rapidly. A bougie was arrested just below the cricoid, and the smallest size could not be passed through the stricture. There was some thickening in the lower part of the neck, behind, and on each side of the trachea. Laryngoscopic examination showed that the left vocal cord was quite paralysed, and some œdematous swelling over the arytenoid cartilages. With such signs, it was obvious that the part was affected with malignant disease in the upper third of the œsophagus, and it was equally clear that he would succumb to starvation unless something was done to enable him to take more nourishment. In these cases, Mr. Legg pointed out, there are two alternative methods of treatment: either to perform gastrostomy or to pass a tube through the stricture and leave it *in situ*. This latter method was, in his opinion, inferior to gastrostomy. Moreover, it was not always possible to use it. In this patient, a tube could not have been got through the stricture, as the narrowing of the lumen was so great, and the site of the disease being in the upper part of the œsophagus, and close to the opening of the larynx, the part would probably not have retained the tube on account of the cough and irritation set up by its presence. Gastrostomy was, he thought, a very satisfactory operation from the point of view of the patient always being able to take enough nourishment, and it had few drawbacks. As it is performed nowadays, there is very little leaking of the stomach contents, and the skin around the opening rarely becomes excoriated. It frequently is never reddened for more than half an inch, so the discomfort to the patient is exceedingly slight. The operation has a low mortality, if it is done before the patient is extremely exhausted and in the last stages of his illness. The operation is indicated (1) when there is absolute inability to take liquids or solids, provided the general condition is fairly good; (2) when there is great difficulty in swallowing liquid or solids, or there is regurgitation of the nourishment; (3) when coughing is produced every time the attempt is made to take food. One sometimes sees a patient with carcinona of the œsophagus, who is able to take sufficient nourishment without much difficulty, and whose general condition is fairly good. In such a case, gastrostomy is not necessary. One must remember that the operation is a palliative and not a curative one, and therefore is not to be done unless there is a definite indication for it. After the operation the patient always improves for a time; he puts on flesh, is very often able to swallow again by the natural passage, and is benefited in every way. But it is impossible to say how long such improvement will last. Some of the most hopeful cases die suddenly from perforation into the trachea causing septic pneumonia, or from hæmorrhage. Other cases will live a few weeks to three or four months, and occasionally one finds the patient living for twelve or eighteen months. Unfortunately one can never tell beforehand how long the life is likely to be prolonged. But death by starvation can always be avoided, and it should be pointed out to the patient or his friends that this is the chief reason for recommending the operation. In the present case a modification of Franck's method was done. A vertical incision, two inches long, was made through the centre of the left rectus, just below the subcostal angle. A second incision, one and a half inches away from and parallel to the first, was made at the outer border of the muscle, which was split into anterior and posterior layers between the two incisions. A cone-shaped piece of stomach was drawn up into the first incision, and passed between the rectus fibres, so that the apex of the cone appeared at the second incision. Thus the whole cone of the stomach was surrounded by muscle. The apex was stitched to the margins of the second incision, and a hole large enough to admit a No. 10 catheter was made. The catheter was passed into the stomach and fixed by a stitch to the skin, to prevent it dropping in or out of the stomach. The base of the cone was sutured to the rectus muscle and sheath, and the skin incision closed. Before leaving the table four ounces of peptonized milk and 1oz. of brandy were run through the catheter. Mr. Legg said this operation cannot be done if the stomach is much contracted and atrophied; under these conditions one of the other methods has to be selected. The operation just performed gives at least as good results as the others, and is the easiest to perform. There is no danger of septic peritonitis from feeding the patient on the table if the stitching is done accurately. The tube is taken out on the third or fourth day, and subsequently passed when the patient requires feeding.

The patient made a good recovery from the operation; there was no regurgitation through the opening, and he left the hospital much improved in about a fortnight's time. But he died, suddenly, three days later from hæmorrhage.

WESTMINSTER HOSPITAL.

ABDOMINAL TUMOUR — LAPAROTOMY — DISTENDED GALL-BLADDER, GALL-STONES, CHOLECYSTECTOMY.—**MR. TUBBY** performed laparotomy on a female patient, æt. 35 who had the following history: She had suffered some time from pain in the right side below the ribs, and her doctor had detected a swelling. She had been sent up to the Westminster Hospital under Mr. Tubby's care. On admission she proved to be a somewhat spare woman, with a good colour; there were no signs of jaundice. She was able to eat well, and did not at first seem to suffer any inconvenience excepting a dull pain in the right hypochondrium, which was always worse after handling. For three days before operation she had some pyrexia. The diagnosis ot the swelling, Mr. Tubby said, at first was obscure and varying, as its character depended much on the condition of the muscular contraction of the abdominal walls. At times it appeared to extend downwards, and to present characteristics associated with hepatoptosis, more especially as the dulness over the area was variable; but when the muscles were relaxed on subsequent examination, the hands could be made to meet in the right loin, and between them an elongated, hard, tense swelling could be felt running downwards and towards the umbilicus. This swelling was diagnosed as an elongated gall-bladder, probably containing gall-stones. An X-ray examination revealed nothing. Three weeks after admission a laparotomy was performed, and it was at once evident that the diagnosis of gall-stones was correct. As it was probable that the gall-bladder contained pus, a trochar and cannula were introduced, and about three drachms of grumous material were expressed. The gall-bladder was then opened, and three gall-stones removed. One measured half-an-inch in diameter, a second one-and-a-half inches, and a third one-third of an inch in diameter. The large one was tightly grasped by the walls of the gall-bladder, and some force had to be used in squeezing it out. The smallest gall-stone was rounded at that part which looked towards the duct, but was facetted where it came in contact with the large stone. After the removal of the calculi, a probe was passed down to make sure that the common duct was clear. The gall bladder was then removed, the stump being seared with pure carbolic acid, the edges being inverted, and sutures passed so as to bring the peritoneal edges in contact. Strips of gauze were packed around the stump, and the abdominal wound closed, excepting where a small aperture was left for the ends of the gauze strips. Mr. Tubby said that in this case at first there had been considerable difficulty in determining the nature of the tumour, and this illustrated how essential it was that observation of these cases should be prolonged for a correct diagnosis to be arrived at. In such a case, where the symptoms were not urgent, there was no necessity for immediate operation. He thought that sometimes there was undue haste in performing abdominal sections for exploratory purposes, and sufficient time was not given to form a definite opinion of the nature of the case before operation. The operation itself, he remarked, did not differ in any way from the procedure usually practised in these cases, but he considered it was of essential importance to ascertain that the ducts were free from stones, and to carefully examine by palpation the duodenal wall and adjacent ducts, so as to make certain that no calculus was impacted in these situations.

After the operation the patient vomited for three days at intervals, and then began steadily to recover.

TRANSACTIONS OF SOCIETIES.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held on Thursday, October 24th, 1907.

The President, Mr. T. F. Paul, F.R.C.S., in the Chair.

Dr. W. R. **Warrington** gave an account of the clinical features of a patient suffering from

ACUTE HODGKIN'S DISEASE,

who died within two months of the onset of the disease. The spleen was considerably enlarged, the glands only slightly so. There was high fever, diarrhœa, and marked anæmia, and violent delirium preceded death. The microscopic examination of the glands showed the typical structure of lymphadenoma, as described in the writings of Reed, Andrews, and others. Dr. Warrington alluded to the classification of the acute glandular enlargements.

The **President**, Dr. J. H. **Abram**, and Mr. R. W. **Murray** discussed Dr. Warrington's Note.

Mr. R. W. **Murray** related two cases of

EXTROVERTED BLADDER,

in which he had transplanted the ureters into the rectum. In one of the cases he had, ten years previously, performed a plastic operation, whereby an adequate covering for the exposed mucous surface of the bladder had been made, but as the absence of a sphincter to the bladder rendered the patient's life miserable, it was decided to transplant the ureters into the rectum. The patient died on the eighth day after the operation, from ascending ureteral infection. In the second case a similar operation was performed with some success. After operation the patient, a child of 4½ years of age, was able to retain his urine for 4½ hours. For two months all the urine was discharged into the rectum, but recently urine had escaped anteriorly from the right ureteral surface of the bladder. These cases were brought forward to emphasise the high rate of mortality following upon such operations, which he thought probably amounted to 50 per cent.

Mr. R. C. **Dun** agreed with Mr. Murray that the rate of mortality following implantation of the ureters into the rectum or sigmoid flexure was a very high one. In his two cases, one patient died of shock in 24 hours after the operation; the other patient lived two years and then died of diphtheria. The child was only seven years old at the time of his death, but could then hold his water for an hour.

In a third case of extroversion Mr. Dun had performed the first part of Lilienthal's operation, but this had resulted in the patient's death.

Mr. R. C. **Dun** reported a case of

URIC ACID CALCULUS

successfully removed by operation from a child six years old. The symptoms had been indefinite—slight pain in the hypogastrium and hæmaturia. These symptoms were not aggravated by movement. While under observation the hæmaturia was so slight that it could only be detected by microscopic examination of the urine. There was no enlargement of the affected kidney. An X-ray photograph, taken by Mr. Thurstan Holland, very clearly demonstrated a calculus in the right kidney. Mr. Dun drew attention to the rarity of this condition in children, and to the indefinite nature of the symptoms in the case under consideration. He emphasised the importance of radiography as an aid to diagnosis.

Dr. **Macalister** read a paper on

THE PERSONAL FACTOR IN DIET,

in which he commented upon the great variations which exist in the dietetic requirements of individuals. He referred to his experiences among the boys of a large industrial school, and pointed out the fact that collective dieting, although suitable enough for the majority, proved that there is a small minority of people who cannot live healthily on conventional lines. Having spoken on the other hand of the danger of arriving at conclusions as to what is good for all humanity, because a few people thrive on some specialised lines of diet, he pointed to the frequency with which metabolic diseases occur, and that in many cases they result from the introduction of foods which, although suitable for people having perfect metabolic capabilities, are harmful to those in whom they are imperfect. Dr. Macalister directed attention to the complex and mixed character of the human diet, and to the fact that the amount of animal and vegetable food required by different people varies considerably, some needing much meat, others very little, and that there are some who should not take any at all. With reference to these latter, he mentioned a case which had come to his notice two years ago of a gentleman who by instinct and habit was a pure vegetable feeder, and in whom there was a well-marked pair of adventitious mammillæ. He was a strong, athletic man, a particularly fine swimmer, and full of physical and mental energy, and he certainly thrived, and thrives to this day, without taking any flesh of any description. The polythelia, together with the metabolic peculiarity, present in this case, had suggested to Dr. Macalister the possibility of a reversion to some ancestral type of vegetable feeder which might be present in this and kindred cases. He referred to the normal condition of polythelia present in the embryo, and to the possibility that its persistence might be associated with other developmental peculiarities, rendering the persons different in their metabolic powers from those in whom more perfect conditions had been attained to. He thought the appendix was another vestigeal organ, functionless in the wholly developed, but which might be very useful to those perhaps less perfect people in whom it is long and well-developed, sometimes resembling the organ as seen in the herbivorous anthropoid apes, and he suggested that some cases of appendicitis may result from the constant introduction of unsuitable fuel into the furnace of the economy.

Dr. T. R. **Bradshaw** remarked that the theory that special idiosyncrasies in diet might be explained on the ground of development was quite new, and he was not prepared to discuss it. The practical outcome of the paper was to confirm the adage "What was one man's meat was another man's poison." The accepted views on dietary were not satisfactory. The physician who laid down rules for diet was too apt to be guided by his own likes and dislikes. Chittenden's experiments to show that the accepted minimum of food was too high was confirmed by clinical observation. He quoted the case of an elderly lady with pyloric stenosis, who was liable to kinking whenever the stomach was distended. For the past six years she had lived on about a pint of liquid food a day with the addition of a few biscuits, and had maintained her nutrition and was able to take gentle exercise.

Dr. W. **Carter** said that the differences in the constitutional build of men were recognised by the elder physicians who classified them into bilious, phlegmatic, nervous, sanguinary, etc., and treated them both dietetically and medically according to the sub-division in which they ranked them. Dr. Macalister, in his interesting and suggestive paper, had given an indication of what might prove to be a reliable and scientific basis for a more correct classification. He drew attention to the observations of Mr. W. North, communicated to the Royal Society by the late Sir W. Burdon Sanderson. Mr. North said that the gist of the whole matter was that we had to deal with a machine which had a marvellous power of accommodating itself to the work put upon it, which rendered the problem so complicated that the hope of finding any explanation of the phenomena observed was somewhat distant. One man would do an amount of work upon a given diet which to another man would be simply impossible. If the signs given by Dr. Macalister as possibly indicating a partial reversion to an earlier stage of evolution were found, on further investigation, to be reliable, we should have a valuable clue for the dietetic treatment of many cases.

Mr. Harcourt, Dr. W. R. Warrington, Dr. A. G. Gullan, and Dr. Owen T. Williams also spoke.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Oct. 27th, 1907.

TREATMENT OF ACUTE RETENTION OF URINE.

WHEN one is called to a patient who cannot urinate, it is easy, says Dr. A. Pappa, in the *Journal des Practiciens*, by a rapid interrogatory and by feeling the vesical tumour, to diagnose a case of acute retention of the urine.

How should the bladder be evacuated is the question. To resolve the problem we have at our disposition different means. Some in current use and which, in the large majority of cases, suffice, others, applicable in case of failure of the preceding and in certain special circumstances.

It is indispensable in the first place to understand the cause of the retention in order to apply a correct treatment.

If the patient is suffering from an affection of the nervous system (hemiplegia, ataxy, paralegia, etc.) the retention should be attributed to this condition, and after having explored the canal with an olivary bougie, a flexible or a coudé catheter will easily be passed. But, in general, the obstacle will be found in the urinary organs themselves, and the diagnosis must be made between prostatitis, spasm, stricture, hypertrophy of the prostate, etc. Examination by the rectum is always necessary to clear up any doubt.

If the prostate is found increased in size, painful, tense and hot, it is a case of prostatitis; if there is fluctuation, an abcess is already formed. If the gland is on the contrary normal, the case is one of spasm or congestion of the urethra.

In all these cases, catheterism should yield the place to medical treatment for fear of carrying infection into the bladder. The better treatment is to order a bath and a very warm enema with a few drops of laudanum. If these means failed then the catheter should be used, but only after the canal had been well irrigated with some antiseptic solution, as oxycyanide of mercury (1—4,000). After which a drachm of a solution of cocain (1 per cent.) is injected to reduce the resistance of the membranous portion of the urethra. Frequently, in case of spasm, by this injection alone, the patient is enabled to micturate and in any case it facilitates the passing of the catheter.

When the patient confesses having had gonorrhœa 3. 4, or 10 years or more previously, or a traumatism of the perineum, and if he complains beside of increasing difficulty in urinating, the diagnosis of stricture imposes itself. The canal should be explored by an olivary catheter of a large size, No. 20; if it does not pass, the size is diminished until the right dimension is found. However, generally, the very smallest calibre fails, and recourse has to be had to one or other of Gouley's whalebone or filiform series. If one of these pass it should be left *in situ*, the urine will pass by the side of it, and the patient will be relieved.

If the patient is close on the sixties, the retention is generally due to hypertrophy of the prostate.

For some time, he has had to get up at night to urinate, the jet was slow in coming; then from some congestion caused by coition, copious repast, cold, voluntary retardation in evacuating the bladder, retention suddenly set in.

Here a catheter coudé is indicated. If resistance is felt, no violence should be permitted, a simple manœuvre is generally sufficient to overcome the obstacle.

The instrument engaged in the posterior urethra and maintained firmly in the median line by the left hand near its extremity and the guide held by the right hand, the catheter is pushed gently towards the bladder, while at the same time the guide is drawn out. By this means the curve of the catheter is accentuated, and the instrument penetrates into the bladder. If the attempt has not been successful a finger might be passed into the rectum to guide the catheter by gentle pressure towards the bladder.

When the catheter has penetrated, should the bladder be completely evacuated? If the patient is young and the retention dates only a few hours, it can be emptied without inconvenience; but if the retention has been more prolonged and especially if the patient is of a certain age, the bladder should not be entirely emptied for fear of hæmorrhage *in vacuo*. After withdrawing a quantity, more or less considerable, according to the case, six ounces of a solution of nitrate of silver (1—1,000) should be injected if the urine is not infected. If, on the contrary, the urine is dirty, it should be replaced at the same time as it is withdrawn by a solution of oxycyanide of mercury. Two or three quarts are thus injected, modifying the vesical contents without having emptied completely the bladder. Complete evacuation should only be permitted after 24 or 48 hours, but the catheterism might be repeated every three or four hours.

Another important question is to know if the catheter should be left *in situ*. In spasm of the urethra or prostatitis, never; in stricture, hardly ever, but frequently in hypertrophy of the prostate, and especially when it is not possible for the surgeon to repeat frequently the operation, and when the patient or his attendants could not be trusted with the catheter.

Where catheritism is absolutely impossible, recourse should be had to puncture of the bladder with Polain's apparatus. The pubis being shaved, a capillary trocar is inserted a quarter of an inch from the edge of the pubis, in the median line, and pushed into a depth of from two to two and a half inches. Aspiration of the urine is made without completely emptying the bladder, and a drachm or two of a solution of nitrate of silver (1—500) injected. The trocar is withdrawn sharply, and the small wound sealed up with collodion.

In general, this operation need not be repeated as congestion disappears from the organs and micturation is re-established, otherwise three or four repetitions may be practised without inconvenience.

There are cases where catheritism should not be practised. In urinary abscess it is dangerous. The abscess should be opened largely, and the patient will urinate through the wound. In grave ruptures of the urethra, catheritism should only be done in the operating room, it being the first operation in external urethrotomy.

In other cases, not only has retention to be treated but also urinary infection, for which a whalebone catheter is insufficient to insure the drainage of the bladder, whereas his indication can be filled by internal urethrotomy permitting the placing *in situ* of a No. 15 or 16 catheter.

Finally, puncture of the bladder is insufficient in case of infection or grave hæmorrhage in prostatic patients. Here suprapubic cystomy should be performed in order to drain largely the bladder by a suprapubic drainage tube or to arrest the hæmorrhage.

GERMANY.

Berlin, Oct. 27th, 1907.

THE TREATMENT OF TETANUS.

PROF. TILMANN, of the Surgical Department of the Academy for Practical Medicine, Cöln, has an article on this subject in the *Deutsche Med. Wochenschrift*, 14.07.

A child, æt. 4, was admitted into hospital suffering from gangrene of the arm caused by a horse treading on it. Immediate amputation was indicated. There was no other injury, but notwithstanding this five days after the injury and two after the amputation, the first symptoms of tetanus made their appearance, the disease proving fatal in another 36 hours. As there was no other injury it must be assumed that the elbow was trodden on, and that the poison was introduced into the system in that way. The early removal of the source of infection had neither cut short the disease nor rendered its character milder. From this it may be assumed that amputation does not promise much in the way of treatment. The case was also of great interest from a pathogenetic point of view. A tetanus poison introduced during the first three days after the injury had not set up any symptoms until five days after. This was difficult to explain. Perhaps the tetanus poison has to develope further in the body before it can do any harm; but in cats the disease shows itself three hours after injection of the tetanus poison.

The case agreed best with the theory of Brunner-Goldscheider, which places the point of difficulty in irritation of the ganglionic cells of the spinal cord. The poison reaches these ganglionic cells by way of the peripheral nerves, or in the nerves themselves to the spinal cord. In this case five days had elapsed before the necessary quantity of toxine had reached the spinal centres, and the toxine formed in the wound during the first three days sufficed to set up the first symptoms of the disease. The interruption of the delay did not help.

Herein perhaps lay the reason why antitoxine did not do much good. Perhaps it was used too late, or not in the right way. Behring recommended that we should protect the threatened spinal centres against the tetanus poison by shutting off the afferent nerves by antitoxine. The writer had carried out this procedure in a case of tetanus following an injury to the knee. The tetanus of a medium type that followed the injury rather quickly was arrested after 52 ccm. of an antitoxine = 280A.E. in the lumbar region and into both ischiatic nerves. Along with this the patient had 0.01 grm. of morphia every two hours and 1 grm. of chloral hydrate. One could not say with certainty that the case would have been fatal without the serum, but in any case recovery took place in a week. Otherwise the author had never seen a case in which he could satisfy himself that the antitoxine was of any value. The cases in which the onset was delayed to about the sixth day almost all proved fatal, those commencing after the tenth day nearly all recovered; in the cases lying between these dates the prognosis was according to the quickness of the onset of the symptoms.

The writer did not make prophylactic injections of antitoxine. When should the injections be made? To make injections into the afferent nerves was not possible. Then it was not free from doubt that injections of antitoxine serum into healthy men did no harm. If tetanus bacilli were found in the wound he injected at once.

AUSTRIA.

Vienna, Oct. 27th, 1907.

Retirement of Professor Politzer.

After 46 years practice in the Allgemeinen Krankenhaus, Politzer has now retired from being the head of the department of Otiatria. A few days since a holiday was recognised by his academic colleagues to present him with a "gold plaquette" and an illuminated address endorsed with the names of subscribers from every part of the globe. Politzer was born on the 1st October, 1835, in Alberti, Hungary, and studied at Vienna under Rokitansky Skoda, Oppolzer, and Carl Ludwig, obtaining the doctorate in 1859.

After a short residence with Ludwig in the physiological laboratory he travelled to Würzburg where Tröltsch was experimenting with the ear; thence he went to Paris where Claude Bernard was electrifying the physiological world with animal experiments in the spinal cord, and finally arrived in London where he took interest in Toynbee's work.

In 1861, when he was only 26 years of age, he returned to Vienna, and was appointed the same year to be a Docent in Otiatria by the general consensus of the Vienna Medical Faculty! His lectures were given in the Medical Klinik of Oppolzer, by the kind permission of the professor. In 1870 he was appointed "Extra-ordinarius" lecturer. In 1873 the faculty began to realise the necessity of a special klinik for ear diseases, and finally resolved that one should be added to the Allgemeinen Krankenhaus with Two Extraordinary Professors, Adam Politzer and J. Gruber; the latter for the male department, the former for the females. In 1896 he was raised to the position of Ordinary Professor of "Ohrenheilkunde," but on the retirement of Gruber next year he was left sole director of the Vienna Klinik for Otiatria.

From 1873 till 1897 his ward consisted of 12 beds, where he operated, lectured, and received guests from every civilised country. He could read and make himself understood in German, Hungarian, French, and English; and before going to the last congress in Madrid added Spanish to the list.

Vienna claims him as the first in Europe to put this branch of medicine on a true scientific basis. Demonstrations of the tympanum and Eustachian tube lead to the practice of catheterising. In his response he told in a humorous way how a notable German "specialist" came to his klinik one day, and after seeing the students go through their exercise, said he had been 40 years in practice and never saw the tympanum before!

His experimental researches and writings are now classic, and found in different languages, a fourth edition of his great work, "Diseases of the Ear and Adjacent Organs" (a) being now before the profession in its English translation. But the greatest marvel of his endurance is the recent completion of the first volume of the "History of Otiatria" in his 72nd year, and means to complete the second volume in his 73rd year of his "Geschichte der Ohrenheilkunde."

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Royal Victoria Hospital, Edinburgh.—The Tuberculosis Problem.—An interesting ceremony took place in connection with this institution on Thursday last, in which the principal part was taken by the Right Hon. A. J. Balfour, who formally opened the newly erected adminstrative buildings. The proceedings took place in a marquee erected in the grounds, and were presided over by Lord Dunedin, who, in introducing Mr. Balfour, said that the hospital, which had been erected as a memorial to the late Queen Victoria, was recognised as a national, not a local, institution, and had been fortunate in receiving the patronage and ready help of their gracious Majesties the King and Queen. After a brief account of the history of the hospital from its commencement as a dispensary for tuberculosis, by Dr. R. W. Philip, and remarks by Dr. Underhill, President of the Royal College of Physicians, as representing the medical profession, and by Dr. Leslie Mackenzie, representing the Local Government Board, who dwelt on three aspects of the crusade against consumption—viz., compulsory notification, hospital isolation for advanced cases, and curative sanatorium treatment for the early stages—all three of these existing in Edinburgh—and who also alluded to the recent Act amending the Public Health Act so as to make the latter applicable, without undue hardship to patients, to all forms of infectious disease, Mr. Balfour addressed the audience on the tuberculous problem, and in his speech showed that he had a thorough and statesmanlike grasp of the problems at issue. He paid a graceful tribute to Dr. Philip as the inventor of the idea of a tuberculosis dispensary ten years before it was adopted in any other locality or country, which is rightly to be looked on as the central point in the general campaign against tuberculosis. Most of those present could remember a time when tuberculosis was not regarded as an infectious disease, but since Koch's great discovery we had learned that phthisis, like many other diseases, was due to an invasion of the body by organisms, just as plague, scarlet fever, and small-pox were. Different though all the infectious diseases were, methods of treatment were of three types. We might take, for example, the method of dealing with them by some form of inoculation, long known in the case of small-pox, lately introduced with so much effect into the treatment of other diseases. Then we had the method of diminishing the danger of infection—one of the great objects of the medical reformer being by isolation, by early treatment, and the like, to save those who are not infected from such a strength of invasion as will overcome their natural endowment in the way of resistance with which no one was wholly unfurnished. Yet, said Mr. Balfour, I do not anticipate that we shall ever banish the tubercle bacillus completely from any great tract of country inhabited by man. But though this be so, we can, I suppose, reduce its power of doing evil to an incalculable degree. We have before us what has been done with regard to typhus; it may be that our children will live to see the time when consumption shall be as little known in our midst as typhus is to-day. We have arrived at a condition of affairs in regard to that particular disease so satisfactory that the force of resistance of the community at large is adequate to prevent its making any kind of lodgment in our midst. That is the ideal to which we look forward with regard to tuberculosis. The third method of dealing with this infectious disease is by taking those who are attacked and restoring to them their powers of resistance so that they can throw off the disease and return to their ordinary work re-endowed with powers rendering them immune to any similar invasion. This is the object of sanatoria, and we shall never be able to deal adequately with this subject unless we get into the popular mind the distinction between the various methods of dealing with the disease, and not attempt to do in sanatoria what can only be done in hospitals, or to do in the hospital what can only be done in the sanatorium. The fundamental truth must never be lost sight of—consumption is a disease which can be dealt with if you take it early, but if you allow it to get a fatal grip on the organism, all you can do is to smooth the dying months of the sufferer, but in no sense can you restore him to his place in society or his work in the world. After the address, which was frequently applauded, the Rev. Dr. Macgregor moved a vote of thanks to Mr. Balfour, and Sir Alexander Kinloch paid a similar compliment to the chairman. Sir Alexander Christison presented to Mr. Balfour a silver key with which to open the new buildings. This concluded the formal proceedings, and thereafter the institution was thrown open to the inspection of those present.

(a) Published by Bailliere, Tindall and Cox, and revised by the author.

Notification of Births Act.—The Local Government Board have issued a circular in reference to the adoption by local authorities of this Act. After detailing the provisions of the measure, the Board observe that, in their opinion, there is no need to impose the obligation of notifying births unless steps are taken to carry out the ultimate object of the measure—viz., the giving of advice and instruction to those having charge of the infants. In ordinary circumstances they would not be prepared to consent to the adoption of the Act, unless it appeared that arrangements had been made for this purpose. Local authorities proposing to apply for consent for the adoption of the Act ought, therefore, to be in a position to show that such arrangements have been or would be made.

Royal Crichton Asylum, Dumfries.—Dr. C. C. Easterbrook has been appointed Superintendent of this Asylum, in succession to Dr. Rutherford, whose resignation was announced some weeks ago. Dr. Easterbrook is at present Superintendent of Ayr District Asylum, previously to which he was senior assistant at Morningside.

BELFAST.

Cerebro-Spinal Meningitis.—The epidemic of cerebro-spinal meningitis dies out by slow degrees, two or three cases being notified each week still. There are only five cases of the disease under treatment at the Purdysburn Fever Hospital, as most cases are now treated at home. It appears that a considerable number of cases were secretly kept at home even during the height of the epidemic, when the authorities removed all cases which were reported to them to the fever hospital. Cases of deafness are turning up at the special hospitals, some of which were never recognised as cerebro-spinal meningitis, or, if they were recognised, were never reported.

The Prevention of Consumption.—An important conference took place on Thursday last, when delegates representing the various sanitary authorities in the north-west of Ireland met in Londonderry to discuss measures for the prevention of the spread of tuberculosis. Sir John B. Johnston, chairman of the Londonderry Committee on Tuberculosis, presided, and in addition to the leading men of the district Professor McWeeney of Dublin was present. His Excellency the Earl of Aberdeen telegraphed his good wishes, and Lady Aberdeen wrote promising to attend a meeting at a later date to found a local branch of the Women's National Health Association. After a statement by Professor McWeeney on the subject of tuberculosis, various resolutions were passed, including one advising the adoption of a scheme for providing a sanatorium. The Mayor entertained the delegates to luncheon, and in the evening a lecture was delivered in the Guildhall by the Registrar-General, Dr. Matheosn, B.L., on "Tuberculosis in Ireland." He stated that of the deaths registered in Ireland last year no fewer than 11,756, or 15.8 per cent., were due to tuberculosis, which was in a great degree preventable.

LETTERS TO THE EDITOR.

QUACK MEDICINES.—THE DISCLOSURE OF TRADE SECRETS.

To the Editor of The Medical Press and Circular.

Sir,—If any further evidence be needed to prove the necessity for an authoritative inquiry by a Royal Commission or by any other equivalent means, into the trade in "proprietary articles," it may be found in the report under the above heading in *The Times* of Monday, October 23rd. On Tuesday last Captain R. Muirhead Collins, the representative of the Australian Commonwealth in London, received a deputation (introduced by Mr. K. B. Murray, of the London Chamber of Commerce) of some twenty manufacturers of proprietary medicines, to protest against the proposal that their wares should in future be made to bear labels stating their composition. To assist the Australian Government in eradicating harmful nostrums the deputation expressed their willingness to make a declaration that their articles do not contain any of the drugs which may be prohibited, or any deleterious drugs in quantities injurious to health. The deputation was evidently composed entirely of manufacturers engaged in the preparation of useful articles, such as recognised varieties of foods for invalids and infants, disclosure of the composition of which would evidently destroy legitimate trade secrets. A declaration such as they proposed to supply would undoubtedly meet their case, but such a declaration would have no value, even if true, when emanating from the deliberately fraudulent concocters of quack nostrums and panaceas. It seems a pity that the deputation did not recognise this difficulty and suggest means to dissociate themselves from a traffic which must be as repugnant to them as to all honest men who are acquainted with the facts. The majority of quack medicines are virtually inert; few of them, whatever their pretensions, contain anything more potent than a small cheap purgative dose; whilst many of them, including cures for epilepsy, for organic kidney and liver diseases, and for all surgical diseases, including cancer, are nothing more than coloured and flavoured water, perhaps with a few added grains of some common drug; or, when in the form of ointments, made up of cheap lard coloured and disguised, but lacking any drug of recognisable potency. It is easy for the proprietors of such compounds to declare that they contain nothing harmful. The harm they do is by inducing simple people, misled by cunningly-worded lying advertisements, to rely upon them when their disease is due to organic pathological activity. Functional dyspepsia may sometimes not be made much worse by delay whilst reliance is placed upon some "liver" or "indigestion" cure; but delay in a case of gastric ulcer (a very common occurrence among the poor and ignorant) may lead to a disastrous termination. A bogus heal-all ointment, disguised fat, is harmless in itself, but cases often occur when a wretched patient with some surgical disease, perhaps cancer, which in an early stage was amenable to operation, has allowed the malady to pass into a hopeless phase whilst trusting in the promises of cruel and cynical knavery. These examples, as no medical reader needs reminding, could be extended to vast lengths. Suffice it to say that disclosure of the constituents of advertised quack medicines, and of the structure of bogus apparatus, such as sham electric belts and mechanical cures for deformity, or for deafness, would demonstrate at once, not only to skilled witnesses, but to cultured men of the world, that the trade is merely a cloak for plunder, and ought to be mercilessly suppressed. The trade in "baby quieters" which seems to be enormous in Australia, and which was specially denounced by Mr. Beale, would not be stopped by a declaration such as the deputation suggested. Many of these mixtures are virtually inert frauds; the harm is done by reliance upon them instead of attention to the cause of the infant's disquiet—nearly always improper food and feeding. When baby soothing medicines contain narcotics and anodynes, which perhaps cannot be classed as "drugs injurious to health," they help by masking the pain to lead the infant towards death, or to survival as a ricketty and "scrofulous" wastrel. They form, as Mr. Beale pointed out, a potent contributory factor in the prevailing preventible infantile mortality, and the direct cause of death in large numbers of instances.

I am, Sir, yours truly,

Henry Sewill.

OBITUARY.

THOMAS MICHAEL DOLAN, M.D.Dubl., F.R.C.S., L.R.C.P.Ed., L.S.A., OF HALIFAX.

We regret to record the death of Mr. Thomas Michael Dolan, of Halifax, which took place on the 22nd inst., after an illness of many months, at the age of sixty-three. Deceased was a native of Cashel, county Tipperary. His medical training was at Durham and Steeven's Hospital, Dublin. In 1869 he was appointed medical officer of the Union Workhouse, a position he retained to the time of his death, and in that office assisted in the carrying out of several reforms, notably the erection of special hospital wards and the substitution of professional nurses for pauper attendants. He was the author of several works on medical subjects. One of these, published in 1878, was his "Rabies and Hydrophobia." In the hydrophobia competition for a prize offered by Mr. V. F. Bennet Stanford, in 1879, and open to all nationalities, Dr. Dolan sent in a contribution so full of merit that, on the recommendation of the adjudicators, the special prize of £50 was raised and awarded to him. He wrote a good deal on life insurance, and in 1881 he secured a prize of £100 in a competition on this subject instituted by the Equitable Life Assurance Company of the United States. The following year he obtained the Roylston Prize, amounting to 300dols., for an essay on "Sewer Gas: Its Physiological and Pathological Effects on Animals and Plants." and in the next year he won the prize given by the Medical Institute of Valencia, Spain, for his essay on "Heart Disease." In recognition of these successes his brother practitioners in Yorkshire entertained him to a complimentary dinner. Dr. Dolan wrote much in various medical journals on the question of workhouse infirmaries and their medical service. In 1885 he undertook the editorship of the "Provincial Medical Journal," and continued as such until he established the "Scalpel," a medical periodical which attained a high place. He became F.R.C.S. of Edinburgh in 1879, and a Doctor Medicine of the University of Dublin in 1883.

WILLIAM HENRY DAY, M.D.St.And., M.R.C.P.Lond.

We regret to announce the death of Dr. William Henry Day, M.D., late of Manchester Square, who died on October 22nd, at Meopham, Kent, at the age of seventy-six. After studying at Bristol and King's College, London, he was admitted a member of the Royal College of Surgeons (England) in 1854, took the M.D. degree of St. Andrews in 1857, and ten years later became a member of the Royal College of Physicians (England). In the Crimean war he was assistant-surgeon to "The Buffs." He was a member of several learned societies, had been secretary to the Harveian Society, and was consulting physician to the Samaritan Hospital for Women and Children. Dr. Day was a considerable contributor to medical literature, his manual on "Diseases of Children" running through two editions.

DEPUTY-SURGEON-GENERAL ROWLAND WIMBURN CARTER, M.D.Calcutta, M.R.C.S., L.S.A.

We regret to record that Deputy-Surg.-Gen. R. W. Carter, of the Army Medical Staff, retired, died on October 20th, at Southsea, in his 77th year. He was admitted a member of the Royal College of Surgeons, England, and a licentiate of the Society of Apothecaries in 1854, and joined the Army Medical Service the same year, serving with the 20th Regt. throughout the Crimean Campaign of 1854-5, including the Battle of the Alma, the siege and fall of Sebastopol, and the capture of Kinbourn. He also took part in the Indian Mutiny Campaign of 1858, and was thanked by the Viceroy and his Royal Highness the Commander-in-Chief for his ability during the cholera outbreak in India in 1859. He served in the Afghan War in 1878-80, receiving another medal, and retired in 1884 with the honorary rank of deputy-surgeon-general.

SPECIAL ARTICLE.

A DESTRUCTOR OF DISUSED TINS IN THE TROPICS.

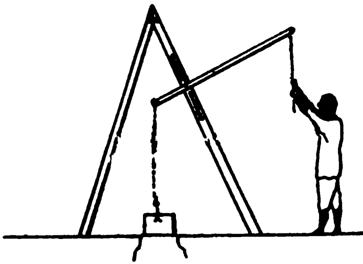
THOMAS MICHAEL DOLAN, M.D.Dubl., F.R.C.S.,

Acting Medical Officer of Health, Freetown, Gold Coast.

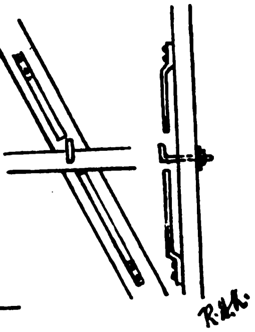
To anyone acquainted with the prominent position occupied by old empty tin vessels in tropical sanitation, suggestions regarding improvement in the method of their disposal will not appear unreasonable. The subject, however, is so closely connected with hospital sanitation that there need be no hesitation in introducing it to the attention of medical readers. The number of empty tins which have contained sardines, potted meats, vegetables, cigarettes, oil, etc., etc., and which will be found in the neighbourhood of houses in the Tropics is almost incredible unless one has witnessed it. Many of these tins when first discarded are appropriated by small dealers and the native poor, who in turn throw them away after some time as useless.

In Freetown, Sanitary Inspectors' systematic visits from house to house, street to street, result in most of these tins being deposited in dust-bins, from whence they are removed by the Sanitary Authority to "dumping grounds" as half-way houses, or to "shoots" for direct deposit in the sea. In other towns remote from the sea the tins are usually buried in pits. The chief sanitary objection in the Tropics to empty tins being allowed to remain as rubbish, is due to their capability of containing water and so favour mosquito breeding. If, then, every tin was crushed as soon as it was empty of its original contents, its water-retaining capacity would be almost entirely obliterated, and it would occupy less space in transport and disposal, the latter being obviously especially important if the disposal has to be by burial. Inasmuch as this crushing on the premises of the individual users would be extremely difficult to arrange for, the next best thing seems to me to provide means for crushing the tins at a "dumping ground." They could be "weeded out" and so dealt with, while the consumable (packing) material is burnt.

I propose a very simple form of crusher which could be easily made in most urban localities, even in the Tropics. It consists in a lever working on a tripod stand; to the end of the short arm is attached a weight which is raised by depression of the long arm and allowed to fall on the tin placed on a nether stone set in the ground. I have not seen this suggestion made for dealing with waste tins in the Tropics,



CRUSHER.



FULCRUM.

though it appears to me such an obvious proceeding that I can scarcely believe it can be novel. I do not suggest that bottles should be dealt with in the same way.

LITERARY NOTES.

MESSRS. CASSELL AND CO. announce a new illustrated serial, "Everybody's Doctor," to be completed in twenty-four parts at 7d. It promises to deal with every kind of common ailment, and to provide common sense information, and, where possible, plain remedies. Medical men will have to look to their laurels!

⁂

DR. SEYMOUR TAYLOR has issued a reprint of his lectures on "Acute Pneumonia." The first deals with the ætiology, symptomatology, prognosis, and complications of pneumonia, and also refers somewhat fully to the pathology of the disease. The second lecture is devoted to the consideration of its treatment. These lectures are interesting reading and give a systematic account of the whole subject.

⁂

THE last monthly number of the *Canadian Journal of Medicine and Surgery* is published in connection with the meeting at Montreal of the Canadian Medical Association. This number is specially worthy of notice as not only containing several excellent original communications, but also on account of the forty pages of half tone illustrations showing views of hospitals, public buildings, and places of natural beauty in various parts of the country.

⁂

WE have recently received a work, entitled "The Wife: Her Book." It is written by Mr. Hadyn Brown, L.R.C.P.,Edin., and published at 3s. 6d. net by Messrs. Sisley's (Ltd.). There is much that is good and wholesome in the book, but its value is marred by the introduction of unnecessary details on "delicate subjects," and of nerve-harassing tales of servant girls who gave birth to illegitimate children. Surely such stories are not suitable reading for young expectant mothers, or even for any woman, who may be expected to buy a book of this nature.

⁂

MESSRS. ROBERT BOYLE AND SON have issued a booklet in which they plead for a natural system of ventilation. The plea we imagine will not fall on deaf ears. As we have often pointed out fresh air is fresh because it is fresh, and not because it is strained and filtered and sprayed and pumped. The complaint usually made by those who live in rooms artificially ventilated is that they feel heavy and stupid after a few hours in the atmosphere provided; which is not surprising when it is considered that all freshness has been taken out of the air. The problem of ventilation is to provide houses with fresh air without draughts, and not an atmosphere, of whatever degree of purity, which has as little sparkle as boiled water.

⁂

FROM the Calendar of the Royal College of Surgeons of England just published we learn that there are 1,387 Fellows on the roll of the College, of whom 1,341 obtained this distinction by examination, 27 were elected as members of 20 years' standing, 17 Fellows by election, and one Fellow elected *ad eundem*. There are 17,544 Members, 398 Licentiates in Midwifery, and 2,111 Licentiates in Dental Surgery. The D.P.H. granted by the Royal Colleges of Physicians and Surgeons is held by 601. The income from all sources during the year amounted to £24,326 17s. 8d., the largest item being derived from fees paid by candidates for the diplomas of the College, £15,219. The expenses for the year amounted to £22,648, leaving a balance at the bankers of £288 10s. 10d. From the Librarian's report it appears that the supply of books has been well kept up during the past collegiate year. Early in 1907 a new library with an annexe was fitted up in proximity to the gallery of the large library, affording additional accommodation.

⁂

"ROYAL Leamington Spa: Its Springs, Baths, and General Attractions." By John Murray Moore, M.D., M.R.C.S., F.R.G.S.. (Leamington Spa: Burgis and Colbourne, Ltd., 1907.) The latest of the many *brochures* written in praise of "leafy Leamington" is a well-intentioned, enthusiastic, and somewhat egotistical but withal interesting and informing description of the ways and waters and other delights of this justly-favoured of our English inland health resorts.

⁂

THE late Sir William Gairdner was the author of a charming work on "The Physician as Naturalist," but it has been chiefly left to the surgeons to found museums which have served as permanent means for the scientific study of Nature. Mr. Jonathan Hutchinson is not only a surgeon of world-wide distinction, but he is an enthusiastic clinician of the field as well as of the ward, and has exemplified in many ways his far-seeing wisdom by providing for the needs of the teacher and the requirements of the student in the establishment of museums both in town and country. Such a volume as that now before us (*The Haslemere Museum Gazette*, edited by Jonathan Hutchinson, F.R.C.S., F.R.S., assisted by E. W. Swanton, Vol. I., Bale and Sons) gives a glimpse into an encyclopædial mind, and provides a storehouse of facts, a record of observations, a fascinating realm of treasures, all of which have lessons or suggestions. It is impossible to indicate the varied and multitudinous items of interest in this volume. Here are astronomical and geological notes, anthropometric data, zoological descriptions, sketches of marine botany, conchological illustrations, pathological details, and much concerning man and his doings. Such a wonderful collection of scientific fragments is rarely brought within book covers. Mr. Hutchinson in this book gives fresh evidence of his virility and versatility.

MEDICAL NEWS IN BRIEF.

Charge of Attempted Abortion.

JOSEPH TOCKERT, 32, was indicted at the Central Criminal Court, on October 22nd, for conspiring, with Agnes Jane Taylor and another person unknown to use on Taylor an instrument with intent to procure abortion. Sir Charles Mathews, in his opening statement, said that Agnes Jane Taylor resided with her husband at Beckenham. In the summer of 1906 Mr. and Mrs. Taylor, who were then residing in another neighbourhood, made the acquaintance of the prisoner. In October of that year Mrs. Taylor made a communication to her husband, and subsequently left their house without his knowledge. Subsequently Mr. Taylor met the prisoner, and Mr. Taylor then informed him of the communication which his wife had made to him, which was to the effect that there had been intimacy between them. About Easter in the present year Mrs. Taylor made another communication to her husband, in consequence of which Mr. Taylor wrote to the prisoner. At an interview, Mr. Taylor told the prisoner that his wife had gone to Lowestoft with him under the impression that he was going to provide a home for her. The prisoner replied that it was true that they had done so. On hearing that, Mrs. Taylor, who had been in the room during the interview, went out, and returning a few minutes afterwards, told them that they were talking to a dead woman, as she had poisoned herself. Mr. Taylor gave her an emetic, sent for a doctor, and she recovered. She had taken five grains of morphia. Early in September Mrs. Taylor became ill, and died. A *post mortem* examination disclosed the presence of wounds, showing that an illegal operation had been performed, which had set up blood poisoning. The prisoner was arrested, and said he knew nothing whatever about it. At the conclusion of the evidence for the prosecution counsel for the defence submitted that there was no case to go to the jury. There was no evidence of any conspiracy. Mr. Justice A. T. Lawrence said he did not think that there was a case that it would be safe to leave to the jury. The facts were quite consistent with the defence that the woman got the operation performed without the prisoner's knowledge and against his wish. He directed the jury to return a verdict of not guilty. The jury found the prisoner not guilty. Mr. White said the prisoner had been committed for trial at the Maidstone Assizes upon the coroner's inquisition for the murder of Mrs. Taylor.

Society for the Relief of Widows and Orphans of Medical Men.

At a quarterly Court of the above Society held recently, Dr. Blandford, President, in the chair, one new member was elected and the death of one was reported. It was decided that a Christmas present of £544 be divided among the annuitants of the Charity, each widow to receive £10, each orphan £3 and the orphans on the Copeland Fund £5 each. Since the last court a donation of £100 had been received from the executors of the late W. Catlin, Esq. Mr. Catlin was elected a member of the Society in 1860. Five letters had been received from widows of medical men who had not been members of the Society asking for relief, but for this reason in each instance it had to be refused, as relief is only granted to widows or orphans of deceased members. Membership is open to any registered medical practitioner, who at the time of his election is resident within a 20-mile radius of Charing Cross. Full particulars and application forms may be obtained from the Secretary, at the offices of the Society, 11, Chandos Street, Cavendish Square, W. The Secretary attends there on Wednesdays and Fridays from 4 to 5 should a personal application be desired.

St. Vincent's Hospital, Dublin.

The annual dinner of St. Vincent's Hospital was held in the Shelbourne Hotel on the 22nd inst. Dr. McHugh presided. After dinner, the toasts included "The King," and "St. Vincent's Hospital," proposed by the President; "Our Past Students," proposed by Dr. Cox, and replied to by Mr. Tobin; "Our Guests," proposed by Mr. McArdle, and replied to by his Honour the Recorder of Dublin, Dr. Magee Finny, and Dr. McWeeney. The dinner was well attended and excellently served.

PASS LISTS.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

The quarterly examinations of the above Board, held in Edinburgh, were concluded on 22nd inst., with the following results:—

First Examination, five years' course.—Of 31 candidates entered the following seven passed the examination:—James Macrae, Caithness; Harold L. de Forges Garland, Oamaru, N.Z.; Haripado Chatterjee, Calcutta; Ruttonbai Nazir, Bombay; Kathleen Reed, Calcutta; Thomas Hardie, Glasgow; and John R. Fleming, Airdrie; and five passed in physics, and one in chemistry.

Second Examination, four years' course.—Of two candidates entered one passed the examination, viz., Adeline M. Watts, Travancore.

Second Examination, five years' course.—Of twenty-seven candidates entered the following nine passed the examination:—Bickford J. Hattam, Melbourne (with distinction); William M. Thomson, Lisburn; Herbert C. Bankole-Bright, West Africa; Henry E. K. Fretz, St. Kitts; Conrad J. Arthur, Grenada; Ulick J. Bourke, London; Charles K. Carroll, India; John W. Robertson, Edinburgh; and William G. Forde, Co. Cork; and three passed in physiology.

Third Examination, five years' course.—Of twenty-nine candidates entered the following sixteen passed the examination:—William T. Lawrence, New York; Millicent V. Webb, Warwick; William G. Forde, Co. Cork; Michael Mulrain, Trinidad; Sakharam Bhagwat, India; William Grant, Arbroath; Shivnarain Rozdon, Simla; Ian MacLeod, Scotland; Dakshina R. Das Gupta, Calcutta; Hugh S. W. Roberts, Wales; Charles W. Kay, Lucknow; John J. Huston, Ireland; Martin Remers, Manchester; Helen Y. Campbell, Natal; Clement H. Heppenstall, Lincoln; and Framroz M. Vajifdar, Aden; and one passed in pathology, and two in materia medica.

Final Examination.—Of eighty-six candidates entered the following thirty-three passed the examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—Shanker P. Gogte, India; Oscar A. McNichol, Canada; Cecil Berry, Wigan; Surendra K. Sen, India; Lionel W. Bradshaw, Wakefield; Helen Y. Campbell, Natal; Horace J. Williams, U.S.A.; Charles A. Ritchie, Nova Scotia; Alban L. B. Best, Melbourne; Frederick B. Elwood, Belfast; Leo Murphy, Midleton; Charles Nyhan, Dromgarriffe; Samuel T. White, Canada; William P. Dillon, Canada; Osler M. Groves, Canada; Arthur Saldanha, India; Percival T. Rutherford, England; Roderick McLennan, Australia; Graham Smith, Ashbourne; Bandla R. Naidu, India; Carunguli S. Mudali, Madras; Crichton R. Merrillees, Australia; George S. Williamson, Scotland; David D. McNeill, Orkney; Ronald Wingrave Duncan, Edinburgh; Claribel F. van Dort, Ceylon; James S. R. Weir, Ireland; Shivshankar R. Soneji, Bombay; Walter Damms, Sheffield; Henry F. Collins, Madras; John A. H. Muller, India; Vinayak S. Sanzgiri, Bombay; and John Miller, Scotland; and eight passed in medicine and therapeutics, two in surgery and surgical anatomy, ten in midwifery, and ten in medical jurisprudence.

The following candidates having passed the requisite examinations of the Conjoint Board in October were admitted Diplomates in Public Health:—William H. E. Brand, Banchory; Douglas Bell, Barrow-in-Furness; John Hunter, Cockburnspath; Hubert J. Norman, Winkleigh; Alexander C. B. McMurtrie, Edinburgh; John Ritchie, Edinburgh; William A. Wilson-Smith, Duns; Alice M. Burn, Edinburgh; Agnes J. Gardner, Edinburgh; Rose Hudson, Edinburgh; Ethel Wiseman, Edinburgh; John McKenzie, Leith; Sohrab M. Hodiwalla, Edinburgh; and Thomas R. Smith, Edinburgh.

At the same Sederunt the following gentlemen passed the first examination in public health:—David J. Roberts, Carnarvon; John N. Meade, Caithness; James S. Edwards, Edinburgh; Mark S. Fraser, Edinburgh; Alfred B. Darling, Edinburgh; and William J. MacKinnon, Biggar.

Trinity College, Dublin.

During Michaelmas Term, 1907, the following candidates passed the Intermediate Medical (Part I.) Examination:—David L. M'Cullough, Euphon M. Maxwell, Charles W. M'Kenny, Richard H. Mathews, Henry H. James, Walter E. Adam, John Gardiner, Hans Fleming, William M. Johnstone, Samuel R. Richardson, Francis J. A. Keane, Victor W. T. M'Gusty, Robert V. Dixon, and Gervase W. Scroope.

Previous Dental Examination.—Physics and Chemistry, Arthur A. Smith; Anatomy and Institutes of Medicine, James I. Kelly; Materia Medica, James I. Kelly and Ernest S. Friel.

Apothecaries' Society of London.

The following candidates, having passed the necessary examinations, have been granted the L.S.A. Diploma, entitling them to practise medicine, surgery, and midwifery:—H. J. W. Barles, A. G. Gamble, C. G. Grey, and E. Wharton.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Liver Cirrhosis in Children, following Scarlatina.—Latterly considerable importance has been attached, especially by the French physicians, to the ætiological rôle played by the infectious diseases in the production of cirrhosis of the liver in children. Bingel (*Jahrb. für Kinderheilk.*, h 65, S 393), now refers to several fatal cases of scarlatina in children, in whom the liver was investigated, and in all of which there was found more or less well marked small round celled infiltration of the periportal tissue. Here and there also there were found patches of necrosis and of cloudy swelling of the liver cells. The further fate of these necrotic areas has been found to consist in a gradual replacement by connective tissue, and the consequent establishment of a genuine cirrhosis. Slight evidence of regeneration of cells was also obtained in the presence of very large multinucleated liver cells at the periphery of the necrosed patches, while a large increase in the number of the smaller bile ducts was also noted. M.

Deposition of Fat and Fatty Acids in the Intestinal and Mesenteric Lymphatic Tissues.—Whipple (*Johns Hopkins' Hosp. Bulletin*, September, 1907, p. 382) writes of "A Hitherto Undescribed Disease" characterised anatomically by the lesions indicated above. The patient was a man, æt. 36, who had been perfectly healthy up to five years previously, when, on going abroad, he began to suffer from pains in the joints, which were very persistent, and from chronic cough. This condition lasted for about four years, and then a chronic diarrhœa became established, with some swelling of the abdomen. The motions were found to contain enormous numbers of fatty acid crystals, and to be white and creamy in appearance. The blood was practically normal, as was the urine, till shortly before death, when some acetone was detected. There were no tubercle bacilli in the sputum, and no re-action followed the injection of tuberculin. A laparotomy was performed, and the mesenteric glands were found to be greatly enlarged, but no attempt could be made to deal with them. Shortly afterwards death occurred with all the symptoms of acetonæmia. At the autopsy the mesenteric glands were found to be greatly enlarged and somewhat elastic to the touch, of an opaque pale yellowish colour, and containing in little cyst-like pockets small yellowish granules. Microscopically these granules were composed of fat globules and numbers of long acicular fatty acid crystals. Numerous giant cells were seen, and a general increase of the connective tissue stroma. The villi of the small intestine were enlarged, the epithelial lining being normal, and the submucous tissue being swollen and packed with deposits of fat and fatty acids similar to what were found in the glands. A peculiar cell with abundant foamy protoplasm and a pale vesicular nucleus was found in both glands and intestinal mucosa. Numerous other changes were found in the remaining viscera, but nothing specially characteristic; some sections of the glands stained by the Levaditi method demonstrated the presence of a peculiar rod-shaped organism which did not stain by the aniline dyes. The writer discussing the case concludes that the symptoms were due to some obscure disturbance of fat metabolism, but of what exact nature it is as yet impossible to say. He suggests the name Intestinal Lipodystrophy as the one at present most applicable to the condition. M.

The Pathology of Acute Lymphocythæmia.—Dudgeon and others give an account (*Journal of Path. and Bact.*, January, 1907) of the pathological changes found in three cases of acute lymphocythæmia occurring in young adult males. The most striking feature in each case was the leucocytic infiltration of the various viscera, the vast proportion of the cells met with being large and small lymphocytes. Mitosis in the lymphocytes was observed, but not to any marked extent; and coarsely granular eosinophil cells were almost entirely absent. This change was even noticeable in the bone-marrow, in which over 95 per cent. of the cells present were of the non-granular type. No free iron was found in any of the viscera. The red cells of the blood were much diminished in number, and in one case a large number of nucleated red cells were found. The white cells were increased, and the total number steadily increased as the disease progressed. Some fine fatty change was present in the viscera of one case. Microscopically numerous capillary hæmorrhages were found scattered throughout the body: the spleen was enlarged in every case, and in one instance contained several infarcts; the lymphatic glands were universally enlarged and in one case somewhat softened; the thymus gland was greatly enlarged in two cases. M.

The Fœtal Circulation Through the Heart.—Pohlmann reviews the more important theories dealing with this subject (*Johns Hopkins' Hosp. Bulletin*, October, 1907, p. 409). These he points out are three in number, viz.—(1) Sabatiers' theory that the currents of blood in the right auricle cross one another, that of the inferior vena cava being directed to the foramen ovale, and that of the superior vena cava entering the right ventricle. This he characterises as physically impossible, morphologically inaccurate and developmentally unnecessary. (2) Wolff's theory that the blood of the superior vena cava entered the right ventricle, and that that of the inferior vena cava was evenly distributed between the two ventricles. (3) Harvey's theory that the blood from the two venæ cavæ became mixed in the right auricle, and that the mixture was then distributed to both ventricles. This theory the writer believes to be the most correct, and to accord best with the results of his own investigations. He obtained experimentally answers to the following queries:—(1) Do both ventricles expect the same amount of blood? This was answered in the affirmative. (2) In what proportion does the inferior vena cava return blood to each ventricle? The answer to this was that it returned it in equal amounts to both ventricles. This result favoured both Wolff's and Harvey's view, but the answer to the third question (3) in what proportion does the superior vena cava return blood to both ventricles? decided finally in favour of Harvey's view, by showing that blood from that vessel was found evenly distributed in the outflow from the two ventricles. M.

The Wood-Tick and Spotted Fever.—Our knowledge of the relation of insects to the spread of disease is constantly growing, and Ricketts (*Journal of the American Medical Association*, October 12, 1907) adds to that knowledge by the report of his experiments on the relation of the wood-tick of the Rocky Mountains to the spotted fever of Montana. He comes to the following conclusions:—(1) Infected ticks exist in the known infected districts. (2) Both the adult male and the adult female may acquire the disease by feeding on an infected animal, and may transmit it to a normal susceptible animal for a period of several weeks thereafter. (3) During either of its intermediate active stages, larval or nymphal, the tick may acquire the disease in the same manner, retain it during moulting, and prove infective when it reaches the subsequent active stage. (4) The infected female may transfer the disease to the young through the egg.

(5) The virus exists in both the salivary glands and the intestine of infected ticks at a certain time; as it also invades the female generative organs, the condition is probably one of generalised infection. The disease is not highly destructive to the tick. Ricketts concludes by urging the destruction of the tick in the infected districts by the same means as have been found effective in dealing with the cattle-tick of the Southern States. R.

The Pathology of Chorion-Epithelioma.—Schmauch (*Surgery, Gynæcology, and Obstetrics*, September, 1907) enters a protest against the current view of the pathology of chorion-epithelioma. He regards this condition not as a true neoplasm, but as what he terms a "cellular infection." By this he appears to mean an invasion of the maternal tissues by certain of the cells or tissues of the placenta-villi or syncytium or both. In some cases this invasion is very slight in degree, and does not transgress the uterine mucosa, whereas in others it may infiltrate the uterine wall, or even give rise to emboli and metastases in the lung. The question whether the epithelial cells thus transplanted or misplaced will be able in any given case to proliferate or not depends on the reaction between them and the tissues into which they stray. It is impossible by microscopic examination of one nodule of the growth to decide whether it is a harmless embolus or part of a generalised metastasis. "There is only a gradual difference," says the author, "between the simple invasion of the uterine muscles by villi and their sequelæ, such as adherent placenta, the common and destructive placentary polyp, and the common and destructive mole; between the localised chorion-epithelial growths, limited to the uterus and placental region, and the villous infarcts, developed by deportation of villi; and finally between those cases in which the lungs were able to retain and master the scattered fetal cells (mostly syncytial and atypical forms), and the typical chorioepithelioma malignum, which becomes generalised through general metastases. Only the latter two types deserve the name of malignant chorioepithelioma." The practical conclusion the author comes to is that the malignancy of so-called chorion-epithelioma is to be judged, not by microscopic examination of part of the growth, but by the general clinical symptoms. This view is upheld by analysis of a large number of cases. We are not able to distinguish, we confess, between what he terms "cellular infection" and neoplasm, in the absence of knowledge of the fundamental pathology of neoplasms. A neoplasm may very well be, in the widest sense, a cellular infection. This point, however, does not tell against the view that there are all degrees of chorion-epithelioma from the perfectly innocent to the definitely malignant. R.

Tumours of the Bladder.—Mandlebaum (*Surgery, Gynæcology, and Obstetrics*, September, 1907) furnishes a valuable paper on the pathology of tumours of the bladder. He divides tumours of the bladder into three groups:—(1) An epithelial tissue group, including papilloma, carcinoma, adenoma, and cysts. (2) A connective tissue group, including fibroma, myxoma, and sarcoma. (3) A muscle-tissue group, the myomata. Primary bladder tumours comprise about 0.7 per cent. of all tumours, and of bladder tumours 90 per cent. occur in males. Of the epithelial tumours 65 to 75 per cent. are malignant. McKenna gives a careful description of the histology of the various forms, which does not differ, however, from the usual description. He notes that papilloma of the bladder not uncommonly passes into carcinoma. The distinction can only be made with certainty by the aid of the microscope, though a papillary tumour which is tightly bound to the bladder wall may with certainty be pronounced carcinoma. Microscopically, the transition shows itself by a proliferation of the epithelium into the stroma, while at the same time it loses its typical arrangement. When squamous celled carcinoma occurs in the bladder, it is due, says the author, to a metaplastic formation of squamous epithelium, the result of chronic inflammation. He has examined five cases of scirrhus of the bladder, four of which, however, were secondary to tumours of the prostate. In two cases of adeno-carcinoma the disease was also secondary to disease of the prostate. The author holds, however, with Limbeck that glands may and do occur in the bladder, and that primary adeno-carcinoma of the bladder has been found. Cysts of the bladder are uncommon, and are said to originate from glands or to be the result of congenital defects connected with the urethra, the Wolffian body, or Gärtner's duct. Myxoma occurs mostly in childhood, and in structure resembles the ordinary nasal polypus. An interesting case of endothelioma infiltrating the base of a papilloma is described. R.

Anomaly of the Cœliac Axis.—McKenna reports (*Surgery, Gynæcology, and Obstetrics*, September, 1907) an anomaly of the cœliac axis of some importance to surgery. The usual division of the vessel into gastric, splenic, and hepatic arteries maintains, but the hepatic artery runs directly into the gastro-duodenal, giving only a rudimentary branch to the liver. The gastric artery, normally the smallest of the three, is large and gives off the large branches which supply the liver. The surgical importance of the condition lies in the fact that in resecting a part of the stomach, some operators are in the habit of doing a preliminary ligation of the gastric artery. If the latter should be supplying the liver, the results would be disastrous, since the arteries of the liver are terminal. It would, therefore, be well for surgeons, before tying the gastric artery, to examine the hepatic vessel. R.

Diphtheroid Organisms in General Paralysis.—Candler (*British Medical Journal*, September 28, 1907), from the result of his own experiments, criticises the findings of Ford Robertson as to the presence of diphtheroid organisms in the blood, fluids, and tissues of general paralytics. He examined the blood, cerebro-spinal fluid, respiratory, alimentary, and genito-urinary traces of the cadaver; the urine and urethras, and the blood and cerebro-spinal fluid during life. The total number of cases examined was 223, 82 of which were cases of general paralysis, and 131 of other forms of insanity. The incidence of diphtheroid organisms in general paralysis was 12.2 per cent., while in other forms of insanity it was 8.4. The highest individual percentage of organisms occurred in the urethras of general paralytics, viz., 16 per cent., compared with 13.6 per cent. in other forms of insanity. The number of cases being small, the statistics cannot be regarded as giving trustworthy results. The examination of the blood and cerebro-spinal fluid was, however, entirely negative. In no single instance was a diphtheroid bacillus observed either in smear or in culture from the blood or cerebro-spinal fluid. The examination of *post-mortem* material Candler regards as very unsatisfactory, owing to the rapidity with which all sorts of organism invade the tissues after death. Moreover, the presence of diphtheroid organisms on the mucous surfaces of perfectly healthy people is by no means rare, and the greater frequency with which it has been found in general paralytics is insufficient to justify any conclusion as to causal relation. R.

Primary Cancer of Vagina with Auto-Inoculation.—Wilson (*British Medical Journal*, September 28, 1907) records a case of the rare disease—epithelioma of the vagina, with the rarer phenomenon of auto-inoculation or contact infection. The disease was present in the shape of two ulcerating patches, one on each side of the entry of the vagina. By the microscope they were found to be exactly similar in structure, conforming to the most common type of cancer of the vagina—the squamous celled. The spread from one side to the other is best explained as auto-inoculation or contact infection or implantation. Similar metatasis from one labium to the other has been recorded more than once, and implantation in the vagina of adeno-carcinoma of the uterus has also been recorded. R.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

M.R.C.S.—Atropine was first recommended by Trousseau in the treatment of asthma. In some cases it acts most beneficially, and has even effected permanent relief. But there is no certainty as to its results.

Enquirer.—Your letter shall receive an early answer.

Pensator.—We cannot express an opinion upon the case without knowing more of the facts. If our correspondent will communicate further with us we will endeavour to advise him. The position, we gather, is an involved one. but whether the ethical point raised can be maintained or not is apparently doubtful.

CURE-I-CAN COMPANY.

The following note from the *Financial News* is not without a certain interest and significance of its own. Company registered by Jordan and Sons, Limited, 120, Chancery Lane, W.C. £20,000 (£1). To acquire the business of preparing and selling "Cure-I-Can" ointment carried on by R. K. Hull, F. W. Dawson, E. Bush, and P. Macdonald, at Leicester, as the Macdonald "Cure-I-Can" Company. No initial public issue. First directors (not less than three nor more than seven): R. K. Hull, F. W. Dawson, E. Bush, and P. Macdonald. Qualification (except P. Macdonald, who requires none), £1,000. As fixed by company.

Student.—The alcohol question, just like vivisection and vaccination and other debatable subjects, will never be settled by argument. Statistics improperly used can always be made to prove anything.

Mr. R. Stewart.—We shall be pleased to give space to a reply to our correspondent.

Dr. Adolf Erdos.—We have made inquiries, and find a company which will. We are communicating with you privately, enclosing prospectus.

EXPECTATION OF LIFE.

A writer in the *Journal of Health* of Paris seeks to plan out the course of life as follows:—First year—infantile complaints and vaccination; second year—teething, croup, infantile cholera, and convulsions; third year—diphtheria, whooping-cough, and bronchitis; fourth year—scarlatina and meningitis; fifth year—measles. By now half the children are dead. The others live on as follows: Seventh year—mumps; tenth year—typhoid; sixteenth year—chlorosis and spinal irritation; eighteenth year—neurasthenia; twentieth year—cephalalgia, alcoholism, and vertigo; twenty-fifth year—marriage (considered, presumably, as a disease). In the twenty-sixth year—insomnia; thirtieth year—dyspepsia and nervous asthenia; thirty-fifth year—pneumonia; forty-fifth year—lumbago and failing sight; fifty-fifth year—rheumatism and baldness; sixtieth year—amnesia, loss of teeth, hardening of arteries; sixty-fifth year—apoplexy; seventieth year—amblyopia, deafness, general debility, loss of tone in the digestive ogans, gouty rheumatism. For the seventy-fifth year is given death—*i.e.*, if there is any body left alive.

Jamaica.—It is rather beyond our ken to say whether there are any hospitals in British Colonies solely officered by coloured doctors and nurses without reference to any European, but we imagine this may be the case in some of the more unhealthy Colonies. It may, however, be a point to refer to the emergency hospital which was exhibited last May at Jamestown (Virginia) at the celebration of the tercentenary of the landing of Captain John Smith. This hospital had negro doctors and nurses entirely, and was provided with the most up-to-date fittings of every description.

Meetings of the Societies, Lectures, &c.

Wednesday, October 30th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. H. L. Barnard: Clinique. (Surgical.) 5.15 p.m.: Lecture: Mr. T. Collins: Myopia.

North-East London Post-Graduate College.—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Thursday, October 31st.

Harveian Society of London (Stafford Rooms, Titchborne Street, Edgware Road, W).—Papers:—Dr. B. H. Spilsbury: Lymphatism in Relation to Death under Anæsthetics. Dr. S. Phillips and Mr. G. French: Cases of Lymphatism.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. E. W. Brewerton: Sympathetic Ophthalmia.

North-East London Post-Graduate College.—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting), Surgical Out-patient (Mr. Carson), X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappell). 4.30 p.m.:—Lecture: Mr. H. W. Carson: Surgical Disorders of Digestion.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Seborrhœa and Psoriasis dealt with as Stages of the same Dermatitis in Symptoms, Diagnosis, and Treatment.

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. Corner: The Irreducible Inguinal Herniæ of Female Children.

Friday, November 1st

West London Medico-Chirurgical Society (West London Hospital, Hammersmith Road, W.).—8.30 p.m.: Clinical Meeting. Cases will be shown at 8 p.m.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. C. A. Parker: Clinique. (Throat).

North-East London Post-Graduate College.—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld), Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Great Northern Central Hospital (Holloway Road, N.).—3 p.m.: Clinical Lecture:—Dr. Horder: Some Points in Connexion with Oral Sepsis (illustrated).

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—3.45 p.m.: Demonstration:—Mr. Stuart-Low: Middle Ear and Labyrinth.

Appointments

Dingle, Percival A., L.R.C.P.Lond., M.R.C.S.. Medical Radiographer to the North-Eastern Hospital, Hackney Road.

Hatherell, Robert Ratcliffe, M.R.C.S., L.S.A., Medical Officer and Public Vaccinator for the Topsham District by the St. Thomas's (Exeter) Board of Guardians, and also Certifying Surgeon under the Factory and Workshop Act for the Topsham District of the county of Devon.

McCollum, J., M.B., Pathologist to the City of London Hospital for Diseases of the Chest.

Pratt, J. H., M.R.C.S., L.R.C.P.Lond., House Physician to the City of London Hospital for Diseases of the Chest.

Vacancies.

King Edward VII. Sanatorium, Midhurst, Sussex.—Pathologist. Salary, £250 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19 Devonshire Street, Portland Place, W.

Carlisle Non-Provident Dispensary.—Resident Medical Officer. Salary £150 per annum, with apartments (not board). Applications to the Honorary Secretary, Mr. G. A. Lightfoot, 23, Castle Street, Carlisle.

Leicestershire and Rutland Asylum.—Junior Medical Officer. Salary, £130 per annum, with board, lodging, and washing. Applications to W. J. Freer, Esq., 10 New Street, Leicester.

Down County Infirmary.—House Surgeon. Salary, £60 per annum, with board, etc. Immediate application to Dr. Tate, Infirmary House, Downpatrick. (See Advt.)

House of Recovery and Fever Hospital, Cork.—Junior Assistant Resident Medical Officer. Salary, £50 per annum, and board. Applications to John Marshall Day, Medical Superintendent. (See Advt.)

Royal National Hospital for Consumption for Ireland.—Resident Medical Officer. Salary, £300 per annum, with house. Applications to Hon. Sec., 13 South Frederick Street, Dublin. (See Advt.)

Births.

Gould.—On Oct. 24th, at Castle Hill House, Shaftesbury, the wife of Harold Utterton Gould, M.B., B.C., of a son.

Greene.—On Oct. 21st, at 124 Crossbrook Street, Cheshunt, the wife of William A. Greene, M.R.C.S., of a son.

Haines.—On Oct. 23rd, at Winfrith, Dorset, the wife of Frederick H. Haines, M.R.C.S., L.R.C.P., D.P.H., of a daughter.

Horder.—On Oct. 19th, at 141 Harley Street, London, the wife of Thomas J. Horder, M.D., F.R.C.P., of a daughter.

Marriages.

Dawson—Platt.—On Oct. 22nd, at St. Anselm's. Davies Street, London, George W. Dawson, F.R.C.S.I., of Portman Street, to Amy Melliar, widow of Frederick Platt, of Barnby Manor, Newark, and eldest daughter of the late Rev. P. G. Ward, vicar of Braughing, Herts.

Gwynn—Downward.—On Oct. 22nd, at the parish church, Whitchurch, Salop, Charles Henry Gwynn, M.D.. to Caroline Mary Downward, only daughter of the late John Downward, Esq.

Moss—Parker.—On Oct 24th, at St. Thomas' Cathedral. Bombay, Edward L. Moss, R.A.M.C., only son of the late Edward L. Moss, F.R.C.S.I., staff-surgeon R.N., to Eileen Emily, younger daughter of Colonel Parker, R.E., retired.

Deaths.

Day.—On Oct. 22nd, at Meopham, Kent, William Henry Day, M.D., late of 10 Manchester Square, London, aged 76.

Hodgson.—On Oct. 21st, at Malvern Wells, in his 90th year, William Pritchit Hodgson, M.R.C.S.E., L.S.A., late 73rd Regt.

Lightfoot.—On Oct. 23rd, at Trevor House, Leyburn, John Parker Lightfoot, M.R.C.S., L.R.C.P., aged 39.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, NOV. 6, 1907. No. 19

NOTES AND COMMENTS.

Materialism v. Medicine.

IN an interview with "General" Booth, some few months ago, the great Salvationist was asked whom he considered the most dificult people to convert. We feel a little ashamed to say that he did not show much hesitation in replying "Doctors; and nurses next." Apparently, therefore, medical men are not only obdurate to the "General's" arguments, but they infect their subordinates with their disbelief. It is, of course, impossible either to prove or to rebut such an indictment, but it is a great pity that good people do not leave medical men to enjoy that liberty of conscience which is one of the greatest blessings of the realm. A religious contemporary deplores the fact that "medical science appears more than ever inclined to find a physical basis for moral qualities"—a statement which seems to show that the organ in question has less grasp of the relativity of mind and matter than even medical scientists themselves. And that, alas, is little enough. But perhaps if there is one prominent factor in the situation, it is the almost complete extinction of the old materialism, which is as rare as the old unbridled individualism of the type that opposed the Factory Acts on the ground of their interference with the liberty of trade. Exact scientific knowledge of the body may keep medical men from falling into the extravagant idealism of Christian Science, but it equally does not land them in the morasses of *Kraft und Stoff*.

Medical Thrift.

It is not often that one has the pleasure of recording practical evidence of the growing popularity of orthodox medicine in the community, but there was an announcement in the papers last week which shows appreciation in a quarter in which it was little expected. "Burglars," it ran, "have broken into South African Institute of Medicine, at Johannesburg, and stolen a quantity of medicine." We do not remember ever having seen crime take this particular form before, but we may congratulate ourselves that in these days of "therapeutic nihilists," when even the most cherished beliefs of our forefathers are called in question, the virtues of drugs still exercise a strong hold on the imagination of the Bill Sykes of South Africa. We would that more detailed information had been furnished, as it would have been interesting in the extreme to learn how the robbers disposed of their plunder. Did they devote themselves to an orgy of calomel and castor oil? Or did they merely select a few items of arsenic and prussic acid for their inconvenient friends? We must await the verdict of history on these questions, but, in the meantime, we are inclined to fancy that the pursuit of pharmacological experiment must have thrown its spell over them, as it does over the eager youths who are induced to enter at the medical schools in the month of October.

Flower Cure.

IT will be impossible in the future for any medical man to sing, without severe scientific reservations,

"The flowers that bloom in the spring, tra-la,
Have nothing to do with the case."

It appears, indeed, likely that they will have a great deal to do with the case, that is, if it be one of insanity. The discovery of the therapeutic value of flowers have been made at the very appropriately named "Bloomingdale" Institute for the Insane, White Plains, U.S.A. Rows of lovely sweet-smelling flowers are placed in rich profusion before the inmates of that asylum, and it is found that the weaker their minds the stronger the influence of the flowers upon them. A few sniffs and a gaze or two have an astonishing effect; paroxysms are calmed, violence evaporates, and philosophical discourse replaces the incoherent mutterings of mania. Statistics as to cures and as to their permanency are not yet obtainable; perhaps the flower treatment has not been sufficiently long on trial; but probably by the time they are forthcoming the Americans will have discovered something even more efficacious, and the figures will be no longer needed. At least the craze—we should say treatment—is harmless, so long, that is, as the flower-pots are not used as weapons of offence, and as evidence of humanity to the insane we are glad to hear of it. What we should like even more to hear is that some steps of a very drastic nature had been taken to make impossible the shocking barbarities lately reported, with regard to the way the insane are treated in the reputedly civilised State of Illinois.

And a Fruit Cure.

THE transition from a flower asylum to a fruit hospital is not an abrupt one. It is announced that a bazaar is shortly to be opened in aid of the "Fruitarian Hospital" in Kent. We confess to an almost reprehensible degree of ignorance as to what a fruitarian hospital is. We know of hospitals for animals, for domestic pets, and even for boots and shoes, but we have never yet come across one for sick apples and sleepy pears. There may, for aught we know, be a "felt want" for such a "new innovation," but the institution in question apparently is not to supply it, for mention is specifically made of funds being wanted to build a children's ward. Are the children then to be fed entirely on fruit—and, if so, on what fruit? Our own knowledge of pediatrics suggests several conditions in which it would be difficult to advise a purely fruit diet, and others in which it would prove distinctly disadvantageous to be cut off from such animal products as milk or such vegetable ones as bread. However, we see that Lord Llangattock is honorary treasurer of the hospital, and we know that his lordship has sympathies already wide enough to include anti-vivisection propaganda and pheasant battues. Perhaps from the products of the latter he is able to supply nitrogenous nutriment when needed.

Inquisitorial Methods at Manchester.

If there is one principal more than another necessary for health authorities to recognise, it is that they rule as representatives of the people, and that the efficacy of their administration depends entirely on how far they carry the people with them. Medical men who pass much of their time in the bedrooms of the poor are far more in touch with the sentiments of the working class than political organisers and party journalists, and we may add, usually far more in sympathy with their just complaints. It appears from what passed at the reception by the Sanitary Committee of the Manchester Corporation of a deputation from the Manchester Medical Guild, that officials of the health department of that city have been acting in a high-handed, offensive, and inquisitorial fashion to patients supposed to be suffering from various infectious diseases who prefer to remain in their own houses, and under the care of their own medical men. Sanitary inspectors, it seems, frequently have the impertinence to enter the bedrooms of sick people, to cross-question them, and even to override the diagnosis of the patient's own doctor. Such proceedings, let us say at once, are insufferable, and none the less so because done in the name of hygiene. To call them un-English is the mildest term that can be applied; to call them outrages on the privacy, decency, and self-respect to which the meanest are entitled would not be at all too strong. We are delighted to see the medical men of Manchester protesting against methods which, apart from everything else, can only bring into loathing and disrepute everything connected with sanitation.

LEADING ARTICLE.

FIRES IN HOSPITALS.

Last week an alarm of fire arose in the largest of our London hospitals. Fortunately, the outbreak, which took place in a laundry on the ground-floor, was promptly extinguished by fire hydrants brought into operation by members of the staff and by the timely arrival of the Fire Brigade. Had the conflagration involved the rest of the hospital the consequences must have been terrible indeed. The wards are large, old, and are more or less continuous from one end to the other of a most extensive and irregular pile of buildings. This incident obviously suggests the desirability of guarding against such disasters by the abundant provision of fire extinguishing appliances, and by the periodical drilling of the whole of the staff in their use. The real lesson, however, to our mind lies far deeper, and we venture to draw the attention of the Metropolitan Hospital Funds to the necessity of the proper construction of all buildings used for the housing of sick persons. Of recent years great strides have been made in the scientific construction of fire-resisting buildings. Wood has been to a great extent replaced by iron, and, given iron girders, it requires little additional outlay to supply floors of incombustible material. The simple addition of stone staircases to such floors constitutes a virtually if not an actually fireproof building. At any rate, the safety of the helpless patients within the walls of a hospital would be enormously enhanced by the adoption of precautions that are suggested by considerations of ordinary prudence and humanity. Of what use is it to provide succour and shelter for the sick poor if we pack them into combustible buildings where they may at any moment be burnt alive. It is no answer to say that such occurrences are rare. Several disasters of the kind have occurred in the United Kingdom, notably one within the past few years, but others of considerable magnitude have happened in other parts of the world. It may be asking too much that all old hospital buildings be demolished and replaced by properly-constructed fire-resisting structures. On the other hand, we can, and do, demand that henceforth no additional hospital premises be erected unless they comply with modern requirements as regards safety from fire. We trust that in future the King Edward VII., the Hospital Sunday, and the Saturday Funds will adopt this condition as one of the chief planks of their policy. Further, as medical charities are universal, it is to be trusted that a similar attitude will be assumed by governing bodies in every part of the United Kingdom. Apart from voluntary supervision, there is another aspect of the question. Why should not local authorities assert their right to control the structural stability (as regards fire risks) of hospital premises? Theatres and other places of public amusement are most carefully and rigorously controlled in this respect. If theatres, why not hospitals, which are permanently inhabited by a manifestly helpless population? If the law of the land be insufficient, so far as the powers of local governing bodies are concerned, then let it be strengthened so as to confer upon those responsible for the protection of the community this elementary capacity for increasing the safety of hospital buildings. It is for the public to insist that henceforth all hospitals shall be built of fire-resisting materials and be properly constructed on fire-resisting lines.

CURRENT TOPICS.

A Costly Asylums Report.

The eleventh annual report of the Asylums Committee of the London County Asylums has just been issued. It is a bulky volume 224 pages large folio size. It includes a great number of reports and an immense mass of statistical information, some of it doubtless of value for future reference, but we venture to assert that a large percentage of the detailed information is absolutely useless to the outside world. If we turn to p. 41, for instance, we find among the accounts sent in from individual asylums an item of 3s. 9d. for "providing and fixing a small shelf in the surgery." The mere printing and publication of this item must cost the ratepayers a considerable proportion of 3s. 9d.. A more absurd and indefensible extravagance it would be hard to imagine, for after the bills are passed by committees and accountants there is surely no need to print details. A little wise pruning would cut down the substance of the book considerably without detracting from its scientific value, or from its efficiency as a control over expenditure. Then, again, we cannot imagine that any practical purpose is served by the printing of many charts (some coloured) and tables on interleaved sheets. The cost of this volume must have been great: we imagine it cannot have been less than £1,000 or £1,500, if we include the work of editing and distribution. As a curious commentary on the diffuse elaboration of this production we may say that we have looked in vain among the mass of accounts for a statement of the cost of production of the annual report. The only presumable entry bearing on the point is that of expenditure on "stationery, printing, postage," etc., to the various asylums amounting to a total of £4,775 7s. 10½d. The ratepayers have themselves to thank if they permit this extravagance to continue without protest. The London County Council, although a non-elective body, has a number of strong and powerful delegates from the various metropolitan boroughs. For many years past The Medical Press and Circular has pointed out the extravagance of the Metropolitan Asylums Board, although at the same time it has been freely admitted that the public, on the whole, has been fairly well served in the matter of infectious disease accommodation, and extremely well so far as ambulance is concerned. In our opinion it is desirable that the constitution and methods of the Board should undergo a Governmental inquiry.

Mr. Birrell and the Tuberculosis Problem.

The deputation from the General Council of Irish County Councils which waited on the Chief Secretary for Ireland last week in reference to the tuberculosis problem in Ireland, received a certain amount of reward for their trouble. They can hardly, indeed, have expected that the full extent of their demands—the provision of sanatoria by the Government—would be granted, since the Treasury is notoriously shy of taking new responsibilities. Mr. Birrell, however, promised that he would strongly urge on the Treasury to contribute to the cost of sanatoria if erected by the local authorities. We are glad to note that the Chief Secretary distinguished carefully between two classes of sufferers from tuberculosis for whom relief is necessary—those in the incipient stages and those who are incurable. Much confusion has arisen from carelessness in not noting that the nature of the relief required is very different for these classes. Mr. Birrell made the useful suggestion that the derelict workhouses throughout the country might be used as sites for the requisite hospitals and sanatoria. He also promised his support to the proposal to make tuberculosis a compulsorily notifiable disease, though we do not quite see his objection to attaching the usual penalties to breach of the law in this respect. In conclusion Mr. Birrell approved of the suggestion that the Local Government Board should be authorised to send lecturers throughout the country, who should educate the people in the means of preventing tuberculosis. The various measures will, if carried into effect, start the campaign against tuberculosis in good earnest.

A Bishop upon Toothache.

The relation of the teeth to the general health is now becoming recognised generally by the "man in the street." A most striking object-lesson was given to that interesting person in the wholesale rejection of recruits during the South African war on the score of defective teeth. It is well that he should have settled convictions upon so important a subject, inasmuch as the destinies of the nation must in the long run be guided by his intelligence. As a sane and reasonable person, he will at once endorse a recent utterance of the Dean of Manchester to the effect that everybody should visit the dentist twice yearly. The justification for that general rule is to be found in the omnipotent maxim which declares prevention to be better than cure. Bishop Welldon, when headmaster of Harrow, used sometimes to say that if any boy complained of toothache, he would give him a hundred lines, on the ground that either he or his parents had not taken the trouble to guard against a perfectly preventible pain. This homespun wisdom is clearly capable of wide extension. Were it applicable to public health an enormous preventive field would at once be thrown open, inasmuch as the major part of disease, according to scientific views, is preventible. Unfortunately, the relations of health authorities to their populations are not quite on all fours with those of headmasters and scholars.

Certificates in Tropical Medicine.

The Royal Colleges of Surgeons and Phycisians of England have decided to grant certificates in tropical medicine to students of the London School of Tropical Medicine who have passed certain special examinations. The certificates are endorsed by two assessors appointed by the colleges, who restrict the privilege to their own diplomates. The wisdom of this new departure appears to be somewhat questionable. The new diploma—for that is virtually the result—simply adds to the chaos of existing qualification; nor is it altogether obvious why the diploma of full medical qualification should not include a knowledge of tropical diseases. The nearest analogous special distinguishing title is that of D.P.H., but the specialism of public health and that of tropical medicine are poles asunder. Then, again, the fact that the London colleges restrict the certificate to their own diplomates embodies the spirit of exclusiveness and of the close corporation that is hardly worthy of the present days of liberal enlightenment. It is tolerably certain that the powerful School of Tropical Medicine which was the first to appear on the medical horizon, will not permit its students for any length of time to remain at any disadvantage that may be attached to the absence of a certificate of proficiency in their special subject.

Boric Acid in Sausages.

Last week a London grocer was fined £5 and costs for selling sausages containing twenty-six grains of boric acid to the pound. Apart from the fact that boric acid may be in itself injurious, there is the obvious objection that by its use the maker may be able to palm off tainted meat upon his customers. In any case, the deliberate finding both of the legal Bench and of the scientific sanitarian is against the use of boric acid as a preservative, a verdict which has the tacit approval of the medical profession. Under such circumstances it is somewhat surprising that a prosecution of the kind under consideration should be of sufficient rarity to attract special attention. There must be an enormous number of sausages adulterated with a similar preservative in other districts of London, where the health of their inhabitants should be no less a matter of solicitude than it is in Wandsworth. As a matter of fact, the infrequency of prosecutions for adulteration of food and drugs suggests a lack of proper public supervision in that particular direction. There are many ways in which local authorities might be brought to book. It would be within the power of any ratepayers' protection society, for instance, to collect and analyse a certain number of samples of various articles bought at random, and to regulate their action according to results thus obtained. Without any great stretch of imagination, it may be surmised that data of considerable practical interest might in many instances accrue from such a step.

Professor Koch and the Crocodiles.

SOME recent reports of the work of Professor Koch in East Africa bids fair, if confirmed, to lead to results of a far-reaching nature. He has found that the *glossina palpalis* breeds not only on the banks of lakes, but also along the streams in the interior right up to their source. He has also observed that the fly in question feeds mainly upon the blood of crocodiles, whereby the deadly trypanosome is spread among those reptiles, and in turn conveyed to man. The energetic glossina, it appears, is able to pierce the skin of the crocodile between the joints of an armour that is impenetrable to an ordinary rifle bullet. The outcome of these investigations is likely to have a vast influence in the future of Central Africa. At present we are able to make an exact diagnosis of the malady of sleeping sickness, and further, thanks to an English medical man, to cure it by injections of atoxyl. It is obviously impossible, moreover, to exterminate the disease by medical treatment alone. It seems equally out of the question to hope to rid a continent of an insect of the wide distribution of the glossina. The logical plan is to attack the crocodiles, and that plan has already been experimented on by Professor Koch. In any case, the crocodile is a creature incompatible with modern civilisation. At the same time, it must be admitted that the reptile undoubtedly serves a useful purpose as a scavenger of African rivers.

A Sea Water "Cure."

OF late a good deal has been heard of a system of treatment of various diseases by the injection of sea water subcutaneously. There may or may not be virtue in the method—that point must be settled by future investigation, but there can be no doubt whatever in the minds of medical men on this side of the Channel as to the undesirable way in which publicity has been given to the system. All kinds of sensational statements have been made as to the results obtained by the discoverer, Dr. Quinton, and enthusiasts foresee nothing less than a revolution in therapeutics by its application. Amongst other things sea water used in the way indicated is said to act as a specific in eczema and kindred diseases in children, and to yield marvellous results in the early stages of tuberculosis. If those claims be only partially justified Dr. Quinton should earn the gratitude of mankind. In the meantime a serious disaster has attended the treatment in the shape of the death from sepsis of a young German noble, who, much against the wish of his friends, submitted himself to the treatment. An accident of that kind, however, does not necessarily detract from the value of the method, whatever that may be. In these days of manifold new cures, it is well for the man in the street to possess his soul in patience before he parts with his money, and submits his *corpus vile* to the hands of the enthusiastic discoverer who is often, maybe, better described, perhaps, as an experimenter.

A Medical Motor Club.

THE medical men of Vienna, it is reported, have started a kind of Co-operative Automobile Club. The object is not so much social as that of providing some sort of organisation which would place the acquisition of a motor within the reach of medical practitioners on reasonable and convenient terms. One good proposal is that manufacturers should be persuaded to build cars specially suited to the requirements of the medical profession. The general idea of purchase is that a moderate sum should be paid down, and the balance settled by monthly instalments until the whole amount is covered. It is stated that the monthly payments will be actually less than the present cost of hiring a carriage by the month. The club is to have its own garage, and branch garages will be opened in various districts as required. The idea seems so good as to be worthy of serious consideration amongst members of the medical profession here at home. The motor-car has come to stay—of that there can be no doubt—and its place in medical practice is becoming more assured day by day. It has often occurred to us that a little timely co-operation might serve to lighten the burden upon professional shoulders in many directions other than the motor-car.

Consumption in West Wales.

THE average man is apt to get weary of statistics, especially in such diseases as consumption, which he regards more or less as the visitation of God. The following figures from West Wales, however, are calculated to give pause to the most cynical philosopher. They are taken from the last return of the Registrar-General—for 1906—of the death-rate from phthisis in the three counties comprised in the West Wales area, viz., Pembroke, Carmarthen, and Cardigan. It appears that in two out of the three counties the mortality is higher than in 1905, and in the third lower than in the previous year, although higher than in 1901. The following table will make it clear:—

DEATH-RATE FROM PHTHISIS, PER MILLION PERSONS LIVING IN THE COUNTIES OF PEMBROKE, CARMARTHEN, AND CARDIGAN IN THE YEARS 1901—1906.

(From the Registrar-General's Reports.)

County.	1901.	1902.	1903.	1904.	1905.	1906
Pembroke ...	1,298	1,296	1,536	1,326	1459	1,312
Carmarthen	1,681	1,688	1,487	1,641	1,391	1,446
Cardigan ...	2,178	2,478	2,121	2,294	2,112	2,316
England and Wales ...	1,264	1,233	1,203	1,236	1,140	*—

* Not yet published.

It will thus be seen that in Pembrokeshire the mortality is higher than in 1901, in Carmarthenshire lower than in 1901, but higher than in 1905, while in Cardiganshire it has reached a higher point than in either of the preceding years except 1902. The necessity of abundant open-air sanatoria in West Wales is evident. Further, it would be well to impress upon the ratepayer of that part of the municipality the necessity of weeding out tuberculous cows from farms and dairies.

Hammersmith and Lady Health Visitors.

ALTHOUGH our lamentable infantile mortality has been prominently before the public for some years past, it cannot be said that many practical remedies have so far come to the front. Among the most promising proposals has been the appointment of lady health visitors, whose duty it is to visit the households of the poor and to instruct them in the elements of child-nursing and of general wholesomeness of environment. The Borough Council of Hammersmith, however, have been recommended by their private Health Committee to dismiss their lady health visitor, appointed in 1906 at a salary of £100. The reasons for this attitude are not known to us, but they must have been somewhat cogent to have prevailed against various protesting deputations of ratepayers. It is disappointing, moreover, to learn that the suggested abolition of office is supported by the Medical Officer of Health. That gentleman is necessarily aware of the excessive mortality of Hammersmith and of the difficulties attached to sanitary problems in so large a poor population. It would be interesting to know what alternatives he has in his mind for effecting a reduction in infantile mortality. Whatever be the ultimate decision of the Hammersmith Council as regards the lady visitor, it is somewhat comforting to reflect that they can hardly be influenced by the paltry reduction of £100 effected thereby, for the whole world has recently been astounded by the revelation of the stupendous sums of money expended on the local workhouse buildings, which in some respects may, without exaggeration, be called fabulous. Truly modern life is full of sharp contrasts!

The Administration of Anæsthetics for Unqualified Persons.

A somewhat remarkable communication has recently been addressed to the *Morning Leader* by Mr. H. A. Barker, a bonesetter, or person who professes to treat bodily injuries and deformities without the guarantee of a surgical qualification. In the course of a sort of semi-scientific harangue upon displaced semi-lunar cartilage in the knee-joint, occurs the following remarkable passage:—"I have treated many thousands of these cases by purely manipulative measures under anæsthetics, and with almost invariably good and permanent results." Incidentally it may be remarked that any practitioner should be able, in the majority of cases, to obtain good results in the kind of injury in question, but permanency of cure is another matter, and he would be a bold surgeon indeed who would prophesy anything of the kind, short of tethering the cartilage to the bone or other radical operation. The question we should like to raise is whether Mr. Barker has the temerity to administer anæsthetics himself or by the aid of an assistant? If he be his own administrator then he exposes his patient to risks that it is not pleasant to contemplate, to say nothing of his own position in the case of an anæsthetic death. If his assistant be unqualified, a charge of manslaughter is not an altogether improbable contingency. Lastly, if his administrator be a qualified medical man—but, even in view of the fact that registered practitioners have recently been found administering anæsthetics for unqualified dentists, we should refuse to believe without absolute and overwhelming proof that such a thing could happen in the case of bonesetters.

PERSONAL.

H.R.H. Princess Henry of Battenberg opened the new children's block of the Rugby Hospital on October 26th.

The Sultan of Turkey has conferred on Sir A. Conan Doyle the Second Class Order of the Medjedieh.

Dr. John H. Dauber has been elected President of the Chelsea Clinical Society for this year.

Dr. George Carpenter has been elected Chairman of the Council of the Society for the Study of Disease in Children.

The Merchant Taylors Company have given a donation of 30 guineas to the Samaritan Free Hospital for Women.

Dr. C. F. Bryan, of Leicester, has been elected President of the Association of Certifying Factory Surgeons for the ensuing year.

Her Excellency Lady Aberdeen has sent a letter to certain general hospitals suggesting the formation of tuberculosis dispensaries in Ireland.

Mr. John Lentaigne, Vice-President of the Royal College of Surgeons in Ireland, has been appointed a Member of the Board of Superintendence of the Dublin Hospitals.

Sir James Barr, M.D., delivered the Bradshaw Lecture yesterday at the Royal College of Physicians of London, the subject being "The Pleuræ; Pleural Effusion and its Treatment."

Dr. Burton Brown, President of the Therapeutical and Pharmaceutical Section of the Royal Society of Medicine, took the chair at the first meeting of that section on October 22nd.

Professor Sherrington, of Liverpool, delivered the inaugural lecture to the Royal Medical Society of Edinburgh at the opening of its 171st session. Dr. A. M. Drennan, President, was in the chair.

Dr. John Carswell, of Glasgow, has been presented with a handsome testimonial and a cheque for £415 by a large number of friends in recognition of his services to the town.

Dr. E. M. Grace, the County Coroner of Gloucester and brother of the famous cricketer, was last week married to Miss Brain, daughter of the late Mr. James Brain, of Cardiff.

The Rt. Hon. Sir Herbert Maxwell, Bart., F.R.S., has been elected Chairman of the Council of the National Association for the Prevention of Consumption. Dr. C. Theodore Williams, M.V.O., has been elected Vice-Chairman.

A meeting of the Board of Management of the Manchester Royal Infirmary was held on October 29th. The retirement of Dr. Mould was announced. Dr. Mould entered the service of the Infirmary at the Cheadle Hospital 45 years ago, and had been constantly associated with the work ever since.

Sir Alfred Keogh, K.C.B., will address a meeting of hospital physicians and surgeons at the Royal College of Physicians, London, asking for their cooperation in working the Territorial Army Medical Scheme. Sir R. Douglas Powell will be in the chair.

A Clinical Lecture
ON
A CASE OF TRAUMATIC EPILEPSY TREATED BY OPERATION.

By THOMAS SINCLAIR,

Professor of Surgery in Queen's College, and Surgeon to the Royal Victoria Hospital, Belfast.

Gentlemen,—The patient before you illustrates the effects of the deliberate removal of a portion of the motor area of the brain in the treatment of traumatic epilepsy—the proceeding sometimes designated Horsley's operation of excision of the epileptogenic centres. It is now more than a year since the operation was performed, and no recurrence of the epileptic fits has taken place. Moreover, the patient is now able to work, and is eager and willing to do so, though during the prevalence of the fits he was incapable of exerting himself with any resolution or continuity of purpose, mentally or bodily.

The personal history shows that the patient was a healthy man, of regular habits, and æt. 33 at the time of the accident in October, 1903. He was struck on the left side of his head by a heavy falling plank. He was unconscious for 27 hours. There were no surface signs of cranial damage, and he left the infirmary, where he had been first treated after a stay of five weeks, fairly well, only a tender spot over the left parietal bone remaining.

After several weeks he was admitted to the Royal Victoria Hospital, having developed the following symptoms:—Insomnia, general weakness, frontal headache, dizziness, very frequent vomiting, and night sweats. Under treatment by rest and bromides the vomiting ceased, and the headache and insomnia had so much improved that he left hospital in three weeks.

Relapses occurred at short intervals during the ensuing eight months, and marked tremor of leg, arm, and tongue appeared, associated with much muscular feebleness, but without atrophy or rigidity. By the autumn of 1904 this amounted to right hemiplegia, and he could neither stand nor walk. In October, 1904, on rising from a chair he had a fit. He fell, and was unconscious; his eyes twisted up towards the left, twitchings, commencing in the right leg and arm, developed, followed by stupor, lasting for two hours. He had no warning sensation or aura. The fits occurred daily for two months, and to a great extent replaced the vomiting of the former time. He declined operation, which was urged, at this stage. Gradually the fits lessened, and so much improvement in the hemiplegia followed that he became able to stand and walk, but he still dragged the right foot markedly. Some trophic changes arose in the right knee, which moved stiffly, with much noisy intra-articular crackling; and his teeth, previously sound, underwent rapid decay. He had nine of them extracted during the next year. In January, 1906, he complained of constant vertical headache; the vomiting and fits were less frequent, he ate and slept well, his hearing, vision, and general sensation were good, and there were no oculo-motor or facial symptoms. His left pupil was larger than the right, and the left optic disc was hyperæmic. His knee jerks were exaggerated, but there were no ankle clonus, atrophy or contractures. He dragged the right foot considerably, but could walk fairly without stick or support. The tremor was then much abated, but still noticeable in the right hand. No urinary symptoms ever arose, and the pulse and temperature were normal.

The propriety of subjecting him to operation at this late stage, and in the face of some amelioration of his symptoms, was debated, but ultimately it was undertaken, on the ground that no further improvement was in progress, and the constant severe headache, tremor, and dejection rendered him quite unfit for any duty. Accordingly, in February, 1906, a large disc of bone was raised over the leg and arm centres on the left side of the brain. No fracture or thickening of the bone existed, and the dura mater showed no pachymeningitis, nor was there any arachnoidal bloodcyst or false membrane to be found. The cortex was discoloured over a small area, and contained some old blood clot, the pia mater was tougher and more adherent, and the density of the cortical area involved was firmer than natural. An exploration through and around this area was made in order to exclude the presence of abscess or underlying cyst, and finally a portion of the cortex, about the size of half-a-crown and nearly half an inch in depth, was excised. The disc of bone was re-implanted, contrary to Kocher's advice, and a perfect restoration of the cranial vault was obtained, after a normal healing, without drainage. The headache ceased almost immediately, and the other symptoms underwent rapid improvement: even the artificial hemiplegia caused by the excision of the convolutions passed off in a few weeks. So encouraged was the patient, that one had to restrain him from a too early resumption of work, which is unwise in these head cases after trephining operations. For a kindred reason the clinical demonstration to you of the result has been postponed for a year or more in order that the permanence of the improvement may be better ascertained and attested.

In analysing the symptoms before operation, to frame a diagnosis, it appeared probable, from the up-and-down character of these, that the cortical irritant was not of a bony nature, either osteitis or fracture of the internal table, which, it must be remembered, can occur without obvious change in the outer table of the skull. The likelihood of a small cortical abscess having formed was also not manifest, unless the night sweats of the early period might appear to suggest it. These perspirations lasted only a few weeks, and were not associated with the subnormal temperature and emaciation generally found in suppurative conditions of the cerebrum. Moreover, an abscess, though it may lie dormant for months, when it begins to cause irritative signs advances from irritation and convulsions to greater compression and coma. The improvement in the hemiplegia seemed inconsistent with the theory of abscess. On the whole, an arachnoidal blood cyst adherent to the brain in the motor area, or a blood clot in a contused cortical area associated with variations in the local circulation from time to time, appeared the most probable construction to place upon the clinical signs. The latter condition was found at the operation, and a degree of condensation or sclerosis with adhesion of the pia mater, resulting from a local non-suppurating cerebritis in the involved area, had evidently followed the original damage. That this damage, contusion, or laceration, had been considerable was clear from the long duration of the so-called concussion signs at the beginning, extending the unconsciousness to 27 hours, as already noted. It was this patch which was extirpated at the operation.

In traumatic, or Jacksonian, epilepsy with local symptoms, the earlier the operation is carried out the better, for the longer the fits have lasted the more likely are they to become habitual and approach the status epilepticus; hence the condition becomes less amenable to treatment as time wears on. The prognosis should not be too sanguine as regards the epilepsy, even in apparently favourable operation cases. A probationary period of at least one year should elapse after an operation before an estimate is formed of the result, for experience shows that there are numerous cases of relapse and consequent disappointment in this branch of surgery. Even the contraction of the cerebral scar, which necessarily forms after an excision like the one above described, has to be reckoned with as potent for mischief in this regard.

The possibility of supplying a bony irritant by the re-implantation of the bone disc must not be lost sight of in epileptic cases. Kocher says it is best, as a general rule, not to re-insert the disc, or fragments of bone, as grafts in these cases. The harsh edges presented to the brain by fragments or tilting of the disc may readily reproduce the convulsions. Certainly the practice of re-insertion should be avoided when the undersurface of the disc is irregular from fracture or osteitis, or when it cannot be adjusted flush with the surrounding vault for want of a good foundation. In the present instance, the conditions being all favourable, the re-implantation was adopted, and for so far there appears to be no cause for regret. Finally, it may be advised that patients who have been operated upon for epilepsy should not be allowed to engage in laborious work involving stooping, worry, or excitement for many months, no matter how gratifying the immediate results may appear.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Edred M. Corner, B.Sc.Lond., M.C. Cantab., F.R.C.S., Surgeon in Charge of Out-Patients St. Thomas's Hospital; Senior Assistant Surgeon, Hospital for Sick Children. Subject: "Deformities of the Foot Associated with Abduction."*

A Supreme Health Authority.

IT is proposed to hold a conference of representatives of sanitary authorities in London to consider the question of the establishment of a permanent union of sanitary authorities of the United Kingdom. The Court of Common Council of the City, at its meeting last week, asked the following gentlemen to represent the Corporation:—Mr. S. Pollitzer (the Chairman of the Sanitary Committee), Mr. H. F. Hepburn (the late Chairman), the Medical Officer of Health for the City, Mr. H. S. Dove (the Chairman of the Port Sanitary Committee), Mr. R. Stapley, J.P. (the late Chairman), and the Medical Officer of the Port of London.

A CASE of smallpox has been notified to the ambulance department of the Metropolitan Asylums Board from St. Pancras and removed to the hospital.

ORIGINAL PAPERS.

ABSTRACT OF

THE BRADSHAW LECTURE

ON

THE PLEURA; PLEURAL EFFUSION AND ITS TREATMENT. (a)

By SIR JAMES BARR, M.D., LL.D., F.R.C.P., F.R.S.E.,

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THE first part of the lecture dealt fully with the anatomy and physiology of the pleura, with the important question of intrapleural, intrathoracic and intrapulmonary pressure. After an exhaustive consideration of ætiology and diagnosis, the learned lecturer proceeded: In the treatment of pleural effusion the question often arises when should you withdraw serum? Effusion is a natural process which, if it continue till after the inflammation has subsided, lessens the risk of pleuritic adhesions; it also keeps the collapsed lung quiet, which is very desirable if there be any active tuberculosis in the lung. A large proportion of cases of pleurisy are tubercular, and the early withdrawal of fluid causes vascular turgesence of the lung, often hastens the dissemination of the tubercle bacilli, and kills the patient. Before I began the substitution of one fluid for another by the introduction of air into the pleural cavity, I was much more chary about early tapping than I am at present. I can now remove the whole of the effusion, even in tubercular cases, at an early stage, with perfect impunity. A considerable number of deaths have followed the complete withdrawal of effusion in elderly persons with rigid chest walls. The danger in such cases arises from establishing too great a negative pressure, which leads to hyperæmia and œdema of both lungs; this can be obviated by the introduction of air. I now recommend the complete withdrawal of the effusion in all cases, but before any great negative pressure is established, and before the patient feels any discomfort, I stop the siphon and introduce about an equal quantity of air to the amount of fluid which I have withdrawn. I then re-establish the siphon, and complete the withdrawal of the effusion. When all the liquid is withdrawn I inject four cubic centimetres of adrenalin solution (1 in 1,000), diluted with eight or ten cc. of sterile normal saline; and if I think it necessary I introduce more sterile air, so as to make the total amount equal to a half or three-fourths of the bulk of the fluid withdrawn; the larger quantity of air is introduced in tubercular cases. By this method the patient suffers no discomfort, except from the slight thrust of the trocar. I prefer the siphon to the aspirator, because you can readily regulate the force of the suction, and as your tube only reaches to a receptacle on the floor, practically your negative pressure never exceeds one pound to the square inch; this force is greatly exceeded by the aspirator, and the greater the negative pressure the greater the risk of secondary hyperæmia and œdema. It is an advantage to introduce a manometer in the air tube, as you can thus avoid producing any positive pressure in the pleura. Of course all aseptic precautions are taken.

The adrenalin solution is introduced to contract the blood-vessels and lessen the secretion. According to Schäfer, Elliott, Brodie and Dixon, adrenalin only acts on unstripped muscular fibre which is innervated by the sympathetic; the pleural vessels belong to the systemic system and are thus innervated, but its effect is not very prolonged; consequently you cannot expect it to lessen the secretion for any great length of time if there be a great negative pressure in the pleura. Although I had good success from its use, before I commenced the introduction of air, I soon recognised the limits of its usefulness. When you remove four or five pints of serous fluid from the pleura, there is a potential or actual cavity left which cannot be filled by a drachm of any fluid. Such a cavity cannot exist in the human body with a surrounding atmospheric pressure of 15 lb. to the square inch. It is filled by—(*a*) the carbonic acid gas which escapes from the serous fluid; (*b*) by the more or less expansion of the collapsed lung; (*c*) by the return of the mediastinal contents, which were pushed or drawn to one side, and the further expansion of the other lung; (*d*) by increased quantity of blood in the chest; (*e*) by elevation of the diaphragm, and (*f*) by falling in of the chest wall. All these events may not suffice to fill the cavity if the amount of fluid withdrawn has been very great, and the lung so collapsed and bound down that it cannot expand. In this case the negative pressure is very great, and under such circumstances it would be absurd to expect adrenalin or anything else to permanently check the secretion. When the use of adrenalin is supplemented by the introduction of air, the negative pressure is lessened or abolished, and the lung gradually expands as the air gets absorbed. By this combined method you can operate early in any case even during the febrile stage, and under no circumstances should you allow the fluid to accumulate to such an extent as to completely collapse the lung; you should tap before the patient suffers any respiratory distress. By the removal of the effusion you often remove an enormous number of micro-organisms, and by the introduction of sterile air you substitute a light, innocuous fluid for a heavy and deleterious one.

(a) Delivered at the Royal College of Physicians of London Nov. 5th, 1907.

Dr. W. Ewart, of London, has recently been injecting adrenalin solution into the pleural fluid preparatory to drawing it off, and he has had good success in thus stimulating the absorption of the effused fluid.

When the pleurisy is practically cured, you will find plenty of scope for ingenuity in trying to restore the function of the lung to its pristine vigour. I have no time to enter into the numerous respiratory exercises which I from time to time recommend, but there is one which each of you can now try on himself—the marked effect of throwing one serratus magnus muscle into, and the other out of, action. The function of a physician used to consist in prescribing drugs and giving some directions about diet, but fortunately these days have passed for ever. I have not told you anything about drugs, though I am a firm believer in their efficacy when appropriately used, as I have not got any specifics for pleural effusion. There is one drug, common salt, which you should as far as possible eliminate from the diet, especially in cases of sero-fibrinous pleurisy on account of its high osmotic equivalent. When you hear men telling you that they gave 10 minims of something or other three times a day, and the fluid disappeared as if by magic, you can envy such credulity, but it is impossible to admire it.

When there is a large quantity of effused fibrin, such as occurs in pneumococcal pleurisy, decalcifying agents such as lemons, citric acid, the citrates of ammonium, potassium, and sodium may be used.

I shall now give you a short account of the history of the introduction of adrenalim and air into the pleural cavity. In August, 1902, I saw regularly, in consultation with Dr. Chisholm, Mr. F. T. Paul, and Mr. R. A. Bickersteith, a lady who was suffering from secondary cancerous deposits in the pleura with effusion. The fluid had to be withdrawn every four days, and it re-accumulated so quickly that she had scarcely a day free from distress in breathing between the aspirations, and I saw that this state of matters could not continue long. Necessity is the mother of invention, and I began to consider how to lessen this secretion. I came to the conclusion to try an injection into the pleura of suprarenal extract, and I fixed upon Parke, Davis and Co.'s adrenalin chloride, 1 in 1,000, as being a sterile preparation. I empirically fixed one drachm or 4 c.cm. as the amount to be injected, and after the fifth aspiration this quantity was used. There was no further secretion, consequently no further tapping, and the old lady spent the remainder of her life in perfect comfort, so far as the chest was concerned. In her memory her husband contributed £12,000 to establish the Liverpool Cancer Research Fund.

Since this case I have injected one drachm of adrenalin solution into every pleura which I tapped, and in only two cases have I had to draw off the fluid a second time. Soon after I began this method—to which no one has laid any prior claim—I commenced, in addition, the introduction of sterilized air to replace the fluid which I had withdrawn. I was led to adopt this procedure by the distress frequently caused to the patient by any attempt to withdraw all the serum; by the usually rapid re-accumulation, especially when there was any negative pressure left in the pleura, or there was a large potential or actual cavity owing to the lung being so collapsed or bound down that it could not expand; by the great risk of collateral hyperæmia and œdema of one or both lungs, especially in those persons with rigid chest-walls; and by the fact that in tubercular cases there is apt to be a rapid dissemination of tubercle through the lung when the pleural pressure is removed. As four-fifths of the air is nitrogen, which is only slowly absorbed, this air pad tends to prevent or lessen pleural adhesions. Since I began the substitution of air for serum I have been able to withdraw the whole of the liquid with perfect impunity.

I exhibited my first and second apparatus for the introduction of adrenalin and air into serous cavities at the Liverpool Medical Institution on November 5th, 1903; and the following week there was a notice of my apparatus in the proceedings of the Medical Institution published in the weekly medical journals.

In the *British Medical Journal* of March 19th, 1904, I published a Clinical Lecture on the Treatment of Serous Effusions, in which I fully described my method and apparatus for treating effusions into all the serous cavities. At that time the idea of injecting sterilized air was quite original, so far as I was concerned, and some of the leading members of the medical profession to whom I spoke on the subject had never heard of any such practice, but I afterwards found that some others, to whose writings I shall presently refer, had been in the field before me.

In the *Edinburgh Medical Journal* of November, 1886, Dr. Theobald A. Palm published an account of three cases where he allowed air to be sucked into the pleural cavity after aspiration. One case recovered after one tapping, another after two, and the third "case took an unfavourable course, and in the course of some months the patient died."

On April 24th, 1888, M. Potain communicated to the Academy of Medicine, Paris, a successful case of pyopneumothorax treated by the injection of sterilized air after the removal of the liquid. His object was to keep the lung compressed until the pleura-pulmonary fistulæ had healed, and to prevent the reproduction of the liquid.

In Italy several papers appeared between 1888 and 1902 on the introduction of air into the pleural cavity by Drs. G. Lava, G. Cavallero, S. Riva-Rocci, and Professor Forlanini.

About or before 1900, Professor Ayerza and his pupil, Dr. Bungé, of Buenos Aires, treated cases of acute and chronic tubercular pleurisies by the abstraction of the liquid and the injection of oxygen gas. They used oxygen as a specific medication against the tubercle bacilli, but as oxygen is more readily absorbed than nitrogen, in no case did the pneumothorax last longer than 14 days. Recently Professor Forlanini has advocated the treatment of phthisis by the repeated introduction of oxygen gas into the pleural cavity, so as to maintain an artificial pneumothorax and thus rest the lung. About a century ago a somewhat similar treatment of phthisis was carried out in Liverpool by the late Dr. Carson and Mr. Robert Bickersteth. They produced a pneumothorax by an external opening into the pleura, but they soon gave over the practice.

In addition to cases in foreign literature, there is in the *Lancet*, November 10th, a reference to a case reported at a meeting of the Société Médicale des Hopitaux de Paris, on October 12th, 1906, by M. Dufour and M. Foix. They successfully removed a large chronic pleural effusion and injected sterile air.

This systematic treatment of pleural effusion by the combined method of the complete withdrawal of the liquid, and the introduction into the pleural sac of adrenalin and sterile air which I may fairly claim to have originated, will, I hope, be more appreciated as it becomes better known. The adrenalin solution is better diluted with two or three times its bulk of normal saline solution.

EMPYEMA.

This is one of those numerous diseases which the surgeons have taken under their own special care, and they have done nothing to advance its treatment, I presume because physics seem to have formed no part of their education. In the case of a child with elastic chest-walls you could not easily mismanage a case of empyema. A considerable number of cases get well in spite of treatment. When a surgeon has to deal with a purulent effusion in the chest, about the only idea which he can get into his head is free drainage, and forthwith out comes a piece of rib and in goes a large drainage tube, expecting it to suck up the liquid from the most to perhaps the least dependent part of the cavity, and utterly reckless as to whether the collapsed lung ever expands again or not. Dr. Otto Grünbaum has devised a useful appliance for assisting the lung to expand in these mismanaged cases, but I do not know of any surgeon who has taken it up. Mr. Arthur Edmunds, to whose valuable work I have previously referred, insists on the anæsthesia being very light when operating on an empyema, so as not to abolish the pleuro-laryngeal reflex, and thus the vocal cords are enabled to play their part in maintaining the pressure within the lungs.

If I were a surgeon, and had to deal with such a case, I would use a local anæsthetic, such as eucaine; or, if thought necessary in any particular case, light general anæsthesia as recommended by Mr. Arthur Edmunds. I would make a free incision in a very dependent spot, about the eighth or ninth intercostal space, in a line with the lower angle of the scapula. If the ribs were close together it would be well to take out a long piece of one rib, and then make a free incision into the pleura. An assistant should firmly compress the side so as to drive the purulent matter out, and allow as little air as possible to enter the chest during the operation. A strip of gauze may be inserted in the wound to keep it open, but no tube should be introduced. I would then apply a large piece of sterile oiled silk over the wound to act as a valve, so as to allow the fluid to escape, and no air to enter. Large aseptic dressings should be applied over the valve. The affected side may be well strapped to prevent movement. I would make the patient lie on or towards the affected side, so as to lessen movement and encourage drainage, prevent him taking any deep inspirations, and tell him to take deep nasal expirations, so as to expand the affected lung, and drive the purulent fluid out of the cavity. He should be instructed to inspire through the mouth and expire through the nose. I would also make him frequently practise the Valsalva method, or blow through a small tube. If the pus be very offensive, or not draining well, the patient can be treated in a continuous bath, and then no dressings will be required.

In these cases the pus is usually fairly fluid, is neutral, or may even be slightly acid in reaction, contains some peptone and a ferment which seems to have the power of digesting fibrin, and thus the lung is not likely to be irreparably collapsed or bound down by adhesions; there is therefore a fair chance of success if the operation be adopted early, and the after treatment intelligently carried out.

The variety of micro-organisms in the pus should be ascertained, and an appropriate vaccine, after the method of Sir A. E. Wright, should be used. Even the stinking empyemata from the bacillus coli often do very well. Tubercular cases are the most troublesome, and usually when the fluid becomes purulent there is a mixed infection. Cases of pyo-pneumothorax are best treated by drawing off the fluid and filling the cavity with sterile air or oxygen. Where the empyema is loculated the surgeon may remove a piece of rib if he choose; he cannot do much harm. Unfortunately Estlander's operation is often necessary, partly owing to early mismanagement of the cases. There must be some effort made to place the treatment of this disease on a more scientific basis than that on which it at present stands.

I have spoken strongly about the surgeons, because I feel strongly, and I am anxious that they should remove this blur from their fair escutcheon. The old wheeze about the physicians not handing the cases over soon enough is now played out. There is still, however, plenty of work for the physicians; prevention is better than cure, and I think in the future their work should lie more and more in that direction. Our aim should be to protect the individual from the ravages of disease and the onslaught of the surgeon, and make the very existence of that individual less and less of a necessity.

DEATH FROM HÆMORRHAGE FROM A MEDICO-LEGAL POINT OF VIEW.

By PROFESSOR HENDRICK, M.D.,
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PART I.

DEATH from hæmorrhage takes place when, in consequence of a solution of continuity at any particular part of the body, such a large quantity of blood is withdrawn that the amount left in does not suffice to carry the necessary amount of oxygen to support life to the various organs, especially the brain.

The quantity of blood lost necessary to cause death from hæmorrhage bears no relation to the amount in the whole system, but is dependent first upon age; the relative quantity of blood the loss of which could be borne by adults without injury to health will kill a child. Secondly, on the general condition of the individual. Persons of weakly constitution, especially with a diseased condition of blood—such as often comes on after exhausting diseases—as well as those with pulmonary and cardiac diseases, which hinder oxydation of the blood and the rapid blood supply of the body, bleed to death more rapidly than healthy individuals. In such cases a disease accompanied by hæmorrhage will result in death, when it would not under normal circumstances. Thirdly, the loss of blood necessary to cause death is dependent on the kind of blood lost, whether arterial or venous. Arterial blood contains nutrient material indispensable to the life of the tissues (oxygen); venous, on the other hand, contains the cast-off materials of the tissues (carbonic acid). It is at once clear that the body bears a loss of venous blood better than that from an artery. Fourthly, the amount of loss required to cause death depends on the length of time the bleeding lasts, whether it is rapid and continuous, or whether there are interruptions of hours or days. This, as the experiments of Juergenson have shown, is explained by the fact that a loss of blood is quickly compensated by reflux of lymph out of the tissues, and so when the bleeding is interrupted, a substitute for the lost blood takes its place, and so losses with interruptions are borne when without a break they would be fatal. In this way a man may gradually lose a quantity greater than the whole quantity originally present in the body.

In general it may be said: To bring about death from hæmorrhage, the loss of a very considerable part of the whole of the blood of the body is necessary; the loss of half of it causes death in most cases; the loss of still greater quantities does so with certainty (Oesterlen). Experiments on dogs on bleeding have shown: dogs survive a loss of blood when 4 per cent. of the body weight, = 52 per cent. of the whole quantity of blood, is withdrawn; they die with a loss of blood of 5.5-6 per cent., = 64-72 per cent. of the total amount of blood. To bring forward decided figures, Seydel, amongst more recent authors, gives a loss of 1,500-1,800 grammes as the average amount that would prove fatal for a medium-sized man. Börnträger and Berg give 1,800 ccm. as a mean for internal hæmorrhage. There are variations from 1,500-3,000, but extremes are rare. Casper-Liman consider it idle to fix the amount necessary to cause death for medico-legal purposes, however interesting for physiology. It is not so important in practice to determine the amount of blood accurately as one would at first think, as the quantity of blood comes into question diagnostically only in internal hæmorrhage; in external hæmorrhages the amount cannot be measured.

The diagnosis of death from hæmorrhage may sometimes be determined before the body is opened on the evidence of unbiassed witnesses who have witnessed the occurrence. The symptoms under which death takes place from external hæmorrhage under ordinary circumstances are the following: A large stream of blood spurts out of the wound, the wounded man sinks with a cry to the ground, a pallor spreads over the features, the tongue becomes pointed, the breathing stertorous, the limbs cold; the sufferer throws his limbs about, then clonic convulsions supervene, and at last death. In such a case a post-mortem examination only confirms the diagnosis already made. In other cases in which eye-witnesses have not been present, but the body has been found some time after the death has taken place, when it has taken place from external hæmorrhage, numerous traces will lead to a diagnosis. The blood may lie in great pools upon the floor, or it may have sunk into the soft soil; it may have spurted against walls or other objects; the clothes may be soaked through, or the blood may have run down the body. The forensic surgeon must carefully note all traces, and from them estimate the amount lost. For this it may be necessary to examine the soil, the clothes, and other objects as regards saturation, if the blood is dried in. However, the quantity of blood that has escaped, as has been mentioned, can only be imperfectly estimated. Moreover, it has to be considered that the blood may have been washed away; the body may have been removed from the place where the death took place; and in this way all traces of blood may have been lost. In such cases, as in all cases of death from internal hæmorrhage, the diagnosis can only be made from what is seen on opening the body. The findings on doing this are the following: The skin is a waxy white; Seydel describes it as a whitish yellow; the colour of the mucous membranes of the lips and conjunctivæ is almost white. According to Caspar-Liman, exceptions to the waxy white colour are not infrequent ("cases are not rare where a practised observer would not think of death from hæmorrhage, the colour of the body being quite the usual one"). One result of the skin being empty of blood is the imperfect formation of discoloured patches; they may be absent altogether.

Views differ on this point. According to Divergie (quoting from Sachs), the death patches are always absent, whilst Maschka and Caspar-Liman describe them as rarely so. Hoffmann saw them repeatedly; Chlumsky had the opportunity of noting their absence on three successive days after death. He remarks that Divergie's case is not conclusive; it is not stated at what time after death the autopsy was made, and whether it was not before hypostasis could have taken place. Börnträger and Berg describe the total absence of discolourations as rare. Seydel speaks of slight patches. If, with Sachs, one draws the actual conclusions from these various views, we come to the following as regards the patches: (*a*) hypostasis is slow in the bodies of those who have bled to death; (*b*) in rare cases the discolourations may be absent altogether; (*c*) the patches are smaller and paler. Rigor mortis in these cases does not differ from the ordinary.

Examination of the body internally shows general anæmia of the vessels and parenchymatous organs in a varied but always high degree (Oesterlen). We should not look upon the bloodlessness as if every drop of blood had left the body, as the quantity that has escaped depends, as already mentioned, on a number of factors. Börnträger and Berg also, in their latest work on the subject, remind us that we must not expect a complete emptying of the body. It has also often been shown by experiments on animals that in deaths from hæmorrhage all the blood does not leave the organs. All the larger venous trunks are bloodless, or at least show a want of blood; but it is to be noted that the veins of the pia mater from gravity are rarely empty, but generally visibly filled. Caspar-Liman give a special warning not to doubt from this fact that death has been the result of hæmorrhage. The cavities of the heart are generally empty, but they may contain a small quantity of blood. It is rarely that the so-called sub-endocardial ecchymoses are absent (Hofmann, Puppe). The paleness of the mucous surfaces of the œsophagus, stomach, intestines, and trachea, amounting to a whitish yellow, is very pronounced. The quantity of blood in the glandular organs varies. The lungs and brain show remarkably little blood, the spleen and liver are generally very pale, whilst the kidneys often show a considerable quantity. On section the organs are dry. The lungs are gray in colour, the brain yellowish white, the spleen a pale reddish, the kidneys are from a clear grey-red to clear grey, the liver pale brown if pigmented, or pale yellow if fatty.

The general absence of blood, however, is not an absolutely certain sign of death from hæmorrhage, as even when pronounced, it may be found in the bodies of those who during life have suffered from poorness of blood, conditions of lingering exhaustion, from tuberculosis, malignant tumours, or long-continued suppurations. In the latter cases accompanying symptoms—dropsy, emaciation, decubitus—will appear, whilst on the other hand the source of the bleeding is conclusive as regards diagnosis. Further, general bloodlessness is met with in bodies in which decomposition has taken place, in which, in consequence of putrefaction and permeability of the vessels, the blood has trickled through and left the vessels, or has evaporated, whereby diagnosis is rendered more difficult.

Death from hæmorrhage may therefore be assumed when signs of internal or external bleeding are present, and a solution of continuity in the vessels is seen as the source of the hæmorrhage, the latter with the limitation that, according to Caspar-Liman, the discovery of the source of the hæmorrhage is not always possible in internal hæmorrhage, and therefore not always necessary; further, if the above described general bloodlessness is present, the body is not decomposed, and all other causes of death are excluded.

The following forms of death from hæmorrhage are distinguished: It may be from internal or external bleeding; it may be acute and uninterrupted; or it may take hours; it may have intermissions of days (aneurysm 66, self-help or aid from others, anatomical conditions); it may follow direct from the injury or after the lapse of some time from an intercurrent cause (suppuration, development of aneurysm), and therefore be mediate. The solution of continuity causing it may be spontaneous from morbid changes in the organ, or from only slight violence, or when the organ is sound from the action of considerable violence; or, finally, it may be from simple loss of blood, or as the result of a secondary action of such loss (paralysis from pressure on the brain, heart, lungs, blocking of the respiratory tract from poured-out blood into the air passages, air embolism). In the latter case we speak of complex death from hæmorrhage. This mode of death borders on that from suffocation, but is reckoned as death from hæmorrhage, but is distinguished from it as complicated "verblutungstod." This distinction, however, is not strictly carried out in the larger text-books (Hofmann, Strassmann). Complicated death from hæmorrhage differs from the simple in important points—cause of death, quantity of blood lost, the amount left in the organs—very considerably, and must therefore be kept distinct from it. Very closely allied, and in reality belonging to it, are those causes of death of persons whose blood is poor in consequence of diseases of the heart, lungs, or of the blood itself. By theoretical conclusions, in the absence of certainty, it must be assumed that in these cases the loss of blood causing death is considerably less than in normal bodies, as paralysis of the brain, the ultimate cause of death, takes place earlier. In such cases death would follow from hæmorrhage—as in abortion—when it would not otherwise. From a purely anatomical point of view death from bleeding from an artery is distinguished from that from a vein. When the bleeding is from an artery the course is quicker than when from a vein. A partial severance of a vessel is more dangerous than a total one, as in the latter case a plug can form readily; a transverse division is more dangerous than a longitudinal one from the gaping of the edges of the wound (Oesterlen).

For the exhaustive treatment of a case of fatal hæmorrhage the forensic surgeon must obtain the clearest possible idea of things from the witnesses, and from the wounds—from the infliction of the wound to the death of the patient. If a person with an external wound is found dead, the surgeon must know, if no other cause of death is evident, whether such a wound could cause fatal hæmorrhage, whether, if such is the case, the blood flowed internally or externally, in order, in the latter case, to search for traces of blood; he must be able to decide whether death has followed immediately from the discovered or suspected cause, or whether some time may have elapsed between the injury and the death, and how long a time, and especially whether the injured man could have performed any action; further, whether the bleeding has been continuous or interrupted, and thus whether death has resulted from primary or secondary or late hæmorrhage, and by what factors this was caused (especially anatomical conditions, the formation of aneurysms, any aid that has been rendered by the deceased himself or by others, the presence of wound infections); further, in case of internal hæmorrhage, when a solution of continuity is found on examination, whether it may be spontaneous, when the morbid cause must be looked for, or whether violence has been inflicted, and the nature of it (traumatic); further, whether the case is one of simple or complicated fatal hæmorrhage, and what condition of body may be expected to be found; then what signs for solving the question as to whether the case is one of murder, suicide, or accident; whether self or any other aid was possible; whether it was given, or whether intentionally or unintentionally omitted; finally, whether and how proof is to be adduced of a causal connection between a death from hæmorrhage and a wound inflicted at an earlier period, especially in cases where survivors will benefit from property left by the deceased.

The various forms of death from hæmorrhage must be considered from these points of view. These, according to Sachs, may be classified in the following manner:—(1) Death from hæmorrhage from solution of continuity of the heart; (2) From solution of continuity of the great vessels, arteries, and veins; (3) From parenchymatous bleeding; (4) From rupture of internal organs; (5) From bleeding to death at birth; (6) From fatal bleeding from the female genital organs.

I.—Death from Hæmorrhage from Solution of Continuity of the Heart.

Death may take place from solution of continuity of the heart in various ways. The simplest is that where the heart receives a stab from without; a great stream of blood gushes out, and the wounded man gives up the ghost in a very short time with the symptoms mentioned above. Friedberg (Gerichtsärtliche Gutachten, Seite 144) draws attention to stretching of the arms upwards (*in die Höhe strecken*), as pathognomonic of wound of the heart. In other cases the wound opening is not free, and the blood escapes inwards into the pericardium, the pleural cavity, a hæmato as well as a pneumothorax is formed, and death may be less rapid.

A third mode is when the bleeding takes place into the pericardium. This occurs when rupture of the heart takes place, and there is no external wound, but it may also occur when punctured wounds of the heart are present, when the pericardial wound does not correspond in position to that of the heart itself. The blood expands the pericardium more and more, a sort of shell forms around the heart, and gradually paralyzes it (Rose's tamponnade). The blood here lost amounts to about 300-600 ccm. Death from hæmorrhage is therefore complicated in these cases by paralysis of the heart. Whether the final cause of death in these is the loss of blood or the paralysis is disputed (Fischer, Frierich, Streifensand, Gerard, Richter, Friedberg). Richter and Placzek have also gone into the question experimentally as to whether death takes place slowly or rapidly, without, however, arriving at any decisive result. A fourth method is that in which the wound of the heart is closed by blood clot, the bleeding ceases, and after a time the clot, which may heal in completely, becomes softened by suppuration, and a late hæmorrhage soon leads to death. The case is therefore one of late bleeding set up by the intermediate cause of suppuration. It may be difficult to prove a connection between this bleeding and the previous injury. Finally, cases of death from wounds of the heart occur where the death cannot be explained by either loss of blood or compression of the heart; general shock or wound of the cardiac ganglia must be taken as the cause (König, *Lehrbuch*, 1885, Bd. I., S. 75). That such nerve injuries can cause death, punctured wounds made by needles show, which kill at once without reaction (König). The amount of blood lost varies, naturally, very much, according to the nature of the nerve injury. In such cases we should have to speak of death from hæmorrhage complicated by paralysis of nerves.

Corresponding to these varieties, of course, the time that elapses after the injury is also very varied; it may be five minutes, or it may be several hours, or even days. Hofmann collected 29 cases of punctured wound of the heart, in which death took place in 50, 24, and 1¼ hours (one case each respectively); in 5 cases after a few minutes; in 13 no time was stated. In a case of wound of the heart reported by Rüth, death took place on the fourth day; Picht mentions a death from punctured wound of the heart after 6 days; Bartikowsky after 1¾ hours; Leonpacher after 3 days. Sachs brings forward a case of punctured incised wound of the anterior wall of the heart where several days elapsed after the injury. The varied interval of time between the injury and death is explained by the varied course, but is not based on it. We are not sufficiently clear as to the precise causes. According to Richter, it may be a question of local causes—the part of the heart affected, the size of the wound, the course of the canal of the wound, the direction in which the muscular fibres are severed, or the form of the wound. In the meantime the special influence of these factors has not yet been established. On the other hand, it might be thought that the clotting power of the blood would have an effect, and it is also to be borne in mind that individual conditions (age, general state of the health, morbid conditions of the heart) would have some influence on the rapidity of death. In late death after wounds, the wounded man may do something whereby the inquiry into the facts may be rendered very difficult. Fischer brings forward a number of such cases ("Die Wunden des Herzboundldes Herzbeutels," *Archiv. f. Klin. Chir.*, Bd. IX., 1868). Richter illustrates these cases very clearly by examples. In one case the medical witnesses denied the possibility of a man with a wound of the heart being able to run through a street, so that the official who was making the inquiry came to the conclusion that the deed was committed at the spot where the body was found, and that something was being kept back on the part of the witnesses. In another case, a suicide, no doubt for the purpose of mystifying, after stabbing himself in the heart, had put the knife into his pocket, whereby naturally the inquiry was rendered much more difficult.

A solution of continuity of the heart may occur spontaneously in diseased organs, or traumatically in healthy ones. The diseases of the heart that lead to spontaneous rupture are, according to Eichhorst, myocarditis and its sequelæ, abscess of the heart (acute and chronic), cardiac aneurysms, valvular disease, diseases of the cardiac orifices, the main vascular trunks, of the coronary arteries, new growths, and echinococci in the muscles of the heart. Meyer (Virchow-Hirsch, 1888, II. Bd., S. 172) has collected 24 cases of cardiac rupture, and as the most frequent cause of it has found: narrowing or closure of the coronary arteries (descending branch of the left coronary artery). The consequence of these are patches of softening of the muscles of the heart, hæmorrhagic infarcts, with sudden blocking of the blood supply, fatty degeneration of the myocardium, with gradual closure, wheal-like cicatrices after the healing of infarcts, most frequently on the lower part of the left ventricle. If the heart is changed in this way, rupture may unexpectedly take place as a natural consequence of the progress of the pathological condition, or slight bodily or mental disturbance may be required. As such have been observed: the lifting of a weight, a fatiguing dance, cold water bathing, straining at stool, too full a meal, coition, epileptic attacks, the bolting of a big piece of meat. In the same way, naturally, the slightest external violence may cause a diseased heart to rupture. According to Drenckhahn's collection, the slightest observed traumatic causes have been a kick, or a blow of the fist. Elten rightly says, "Spontaneous and traumatic ruptures of the heart in cases of degeneration of the muscles of the heart pass immediately into one another." To decide whether a case is one of traumatic or spontaneous rupture, the following diagnostic aids must be made use of: Experience has shown that the right auricle is most exposed to rupture, whilst spontaneous ruptures there show where the cardiac diseases present are the most readily developed. According to Klein the rent in spontaneous rupture of the heart is mostly small, jagged, the margins infiltrated with blood, with fatty degeneration in the immediate surroundings. In traumatic rupture the opening is smooth and large; the margins show no sanguineous infiltration, and there is no adjacent myomalacia. The solutions of continuity of the heart produced traumatically, like those of the blood vessels and organs generally, are caused by stabs incised, and gunshot wounds, or a blunt force (falls from a height, being run over, crushing between two fixed or moving objects—for example, the buffers of railway wagons—a blcw, push, or fall). They become the object of medico-legal inquiry, as grave bodily injury, murder, suicide, and in the form of the daily occurring accidents of all sorts (Sachs). The implements that come into consideration in such cases are the incising, stabbing, gunshot implements in general use. That with such gross violence to the heart it happens occasionally that there are no marked external signs of injury is shown by an interesting case (*Zeitschr. f. Med. Beamte*, 1899, No. 16), where a four-year-old healthy child fell from a wagon, struck the fore part of its body, and died in 20 minutes. At the autopsy there were only skin abrasions over the eighth and ninth ribs of the left side, and on the hips, whilst 120 ccm. of blood were present in the pericardium, partly clotted and partly fluid, and a large opening 11 cm. in length in the right ventricle.

On having to decide whether a case is one of murder or suicide in punctured wounds of the heart, conclusions may be drawn from the course of the wound. A perfectly horizontal course is in favour of murder (Maschka). The direction from above downwards is rather in favour of design than accident. Caspar-Liman mention a case in which, from the course of the wound, the question could be answered whether the deceased was stabbed or whether, as declared by the accused, he ran on to the knife.

(*To be continued.*)

RECUMBENCY IN THE TREATMENT OF INFANTILE PARALYSIS.

By ADONIRAM B. JUDSON, M.D.

In the ever-changing treatment of disease the influence of environment is receiving unusual attention, as is seen in the management of tuberculosis of the joints. The influence of the lapse of time is also better understood. Medicines are given in small doses for very long periods and the effects of time on the body are more clearly seen to influence the course of disease and the action of remedies.

In the treatment of infantile paralysis I propose a method which relies exclusively on the influences of environment and the lapse of time. It is applicable only in the very early stage, before the case is likely to be seen by an orthopædic surgeon. As soon as the disease is recognised I would limit the patient to the recumbent position till there is no possibility of further recession of the paralysis. The period of spontaneous recession extends over several months. During this time the difficult task must be undertaken of keeping a child, well in every other way, off his feet at an age when he should be learning to walk. In some cases eighteen months should be occupied in this way. The common belief that such a patient requires exercise, especially of the affected limbs, will give rise to criticism and objections. A simple argument will not prevail in the family circle, and the physician's word will hardly prevent the little patient from having many a romp. And when the case ends there will be differences of opinion. If some lameness results, it may be said that the patient should have had more exercise; and if there is no disability at all, after the strict observance of recumbency, it may be said that there had been very little the matter with the child.

The argument is as follows. It will be recalled that the ill-effects of joint disease are seen more commonly in the lower extremities than the upper, because tuberculous action is subject to resolution in the epiphyses of the shoulder, elbow and wrist, but often goes on to destruction of the articulating surfaces of the hip, knee, and ankle. And when it is noted that the arms are free, while the legs bear the weight of the body, it is reasonably inferred that the joints of the lower extremities when affected, or even suspected, should be protected by either recumbency or appropriate apparatus. The conclusion is a plain proposition, and needs no discussion or verification. It shares the simplicity of Jenner's argument when he traced the relation of cause and effect and prescribed vaccination. In another field Finlay, walking with his eyes open, apprehended the relation of cause and effect and prescribed the sequestration of the mosquito.

The necessity of reforming the environment of the lower extremities having been derived from clinical observations of joint disease, can practical conclusions be drawn in a similar manner from observing the course of infantile paralysis? Disability from this disease is seen eight times as often in the lower as in the upper extremities, and yet in the early stage the paralysis is found in all parts of the motor nervous system. The muscles of the recumbent patient are in very moderate use and in a position entirely favourable to spontaneous recession of the paralysis. The arms and hands retain this advantage when the patient is erect, but impaired muscles in the legs and feet give way at once when they meet the resistance of the weight of the body. They rapidly become elongated and attenuated, and could not well be placed in an attitude more destructive of the possibility of restoration.

When prescribed recumbency shall give to all parts the same environment, recession of paralysis will be equally encouraged in the lower and upper limbs, the disproportion of 8 to 1 will disappear, and the sum of deformity from this disease will be materially reduced.

The value of the method is thus *proved*, but it is not readily *demonstrated.* When comparing methods it is not easy to show that one is better than another. It may always be said that a case cited on behalf of a certain method may have been one that would have done well under any treatment. Tables of carefully recorded cases might lead to correct estimates, but studies of this kind are difficult and have not escaped criticism. Dr. Gaillard Thomas said, with wit and wisdom, that if there is anything more misleading than facts it is figures. Medicine and surgery are still outside of the realm of exact science. Therefore we welcome every logical and reasonable resource of prevention and treatment.

Passive motion, resistance exercises, electricity, massage, local applications, and judicious medication should be continued. They cannot interfere with the treatment proposed, and their observance may make it easier persistently to maintain recumbency—the most important agent of all.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

CYSTOTOMY. — EPITHELIOMA OF BLADDER, WITH MASSIVE CLOTS.—MR. ARTHUR EDMUNDS operated on a man, æt. 68, who was admitted suffering from intense pain in the hypogastrium and along the penis. These symptoms had only been present for a couple of days, previous to which the patient had been in complete comfort. On examination he was seen to be enfeebled and emaciated, and obviously in intense discomfort, with occasional paroxysms of severe pains. He was able to pass his water, but only in small quantities at very frequent intervals, the water itself containing a considerable quantity of blood. Per rectum, the prostate could be felt very slightly enlarged. A full-sized catheter could be passed with the greatest ease, but very little urine came away, although percussion above the pubes indicated that the bladder was a good hand's-breadth above the symphysis. A few drops of fluid were obtained, which resembled the contents of an old hæmatoma, being almost treacley in consistency and consisting mainly of blood. It was obvious that the case presented different characteristics from those of a simple retention of urine. While it is possible in some cases, Mr. Edmunds said, to pass a catheter into the bladder without relieving the patient's symptoms, it is usually because the eye of the catheter has not entered the actual cavity of the bladder, but in this case a large curved prostatic catheter was used, and also a soft rubber catheter, the latter being passed almost to its whole length, and in neither case was there any resistance. Under the impression that the catheter might be blocked, a stylet was passed down, and a clot removed from the lumen of the catheter, which was a complete cast of its interior. Even after repeated attempts, and repeatedly clearing the catheter, the patient could not be relieved, and a diagnosis of a bladder distended with blood clot was made. In cases where the bladder is thus distended, Mr. Edmunds said there are, of course, two methods of procedure. In the first the urethra is dilated, and an attempt made to remove the clots by means of Bigelow's evacuator. The other method, which was adopted in this case, was a suprapubic cystotomy, a method which is to be preferred when the source of the bleeding is unknown, as it enables the surgeon not only to remove the clot but also to deal with the bleeding-point. In opening the bladder the anterior wall was found to be excessively thin, and only a few drops of fluid escaped. On passing the finger into the bladder it at once met with a large solid mass the size of a fœtal head attenæ, completely filling up the viscus. This at first appeared to be a solid growth, but more careful inspection showed that it was a very old blood clot, covered with a certain amount of phosphatic deposit, and intimately adherent to the bladder wall at one point in the neighbourhood of the opening of the left ureter. The mass was accordingly broken up and removed. At the point of its attachment to the bladder, it was very firmly adherent, and upon separating it the base of an epitheliomatous ulcer was disclosed. The bladder was then closed, excepting at the point of insertion of a drainage tube. There were two points of interest, Mr. Edmunds pointed out, in this case:—(1) The method of causation of this enormous polypoid clot. The clot itself on section was very firm, almost as firm, indeed, as the clot which is found in the cavity of an aneurysm, but there was no lamination. A large area of it was decolourised, and it was obvious that it represented the fibrin deposited from a number of successive hæmorrhages, the hæmoglobin being washed out from the network of fibrin by the urine. (2) The question of the procedure to be adopted when an epithelioma of the bladder is discovered after a cystotomy. The bladder is perhaps, he said, one of the most hopeless situations for malignant disease, and although many efforts have been made to eradicate disease in this situation, the results have by no means been encouraging. In the present case excision was obviously out of the question, as the patient's condition was far too bad to allow of any further operative interference, and it was doubtful if it will be ever advisable to attempt such a procedure.

The drainage tube has been left in position for a week, and it is proposed to maintain it as a permanent suprapubic drainage. The man stood the operation well, and has experienced complete relief.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

NEUROLOGICAL SECTION.

MEETING HELD THURSDAY, OCTOBER 31ST.

The President, Dr. C. E. BEEVOR, in the Chair.

Dr. BEEVOR showed a case of

MYOTONIA CONGENITA.

Female, æt. 20 months. General wasting and marked flabbiness of muscles, especially of legs. Passive movements could be carried out through an excessive range. Active movements could all be feebly performed. Trunk muscles stronger, the child could sit up well. No deep reflexes obtained. To electrical currents the muscles were less excitable than normal, but there was no polar change. This was the second case of Oppenheim's disease recognised in this country. Dr. Beevor gave a short account of the condition.

Dr. JAS. COLLIER referred to two cases he had seen. Dr. S. A. K. Wilson mentioned Baudouin's recent findings in an autopsied case; the anterior horn cells and nerve roots were diminished in size, but not in number. Dr. Gordon Holmes considered that these changes did not point to neural degeneration, but might be secondary to disease of muscle. Drs. Campbell Thomson and Wilfred Harris also discussed the case.

Dr. BEEVOR also showed a case of

TOXIC AFFECTION OF MUSCLES AND LOWER NEURONES.

Male, æt. 64, shoemaker. History of illness.—February, 1907, gradual loss of power in hands and feet, beginning in left hand, then right hand, left leg and right leg in the course of two months. On admission in July, 1907, patient was helpless and unable to turn in bed. Slight nystagmoid jerkings on extreme deviation, weakness of both sterno-mastoids. Trapezii, spinati, teres, acted well. Latissimus dorsi, deltoid, biceps, supinator, triceps, flexors and extensors of wrist all profoundly paralysed, the extensors more than the flexors. Fingers could be flexed slightly, but not extended. Flexion and extension of thumb absent; abduction, adduction and opposition just possible. Intercostals strong, diaphragm weak, abdominal recti and erectores spinæ strong. Flexors of hip weak, extensors strong. Flexors and extensors of knee fairly good. Ankle and toe movements very poor. All muscles show rippling fibrillation starting at one end, usually the upper, and spreading to the other. All forms of sensation perfect. All deep and superficial reflexes absent. Electrical reactions.—Upper limb, very marked diminution or absence of reaction to faradism in all muscles; with galvanism a strong current is required, and R.D. is present in most of the muscles. Pathological report on excised portion of muscle by Dr. Gordon Holmes: (1)

Vitreous degeneration of fibres in various stages, hyperplasia of sarcoplasm and nuclear proliferation; (2) simple atrophy of small numbers of fibres; (3) no affection of the intra-muscular nerve fibres. Progress.—Steady improvement from the beginning of treatment by massage and faradism.

Dr. S. A. K. Wilson described a similar case he had seen at Queen's Square. Dr. Gordon Holmes said that the vitreous change in the muscle was indicative of toxic degeneration of the muscle, and was never secondary to nerve disease.

Dr. Wilfred Harris showed a case of

SLOWLY PROGRESSIVE HEMIPLEGIA.

A woman, æt. 35, in September, 1905, had some pain in muscles of the left upper arm, and noticed that the hand became very blue and cold. In January, 1906, she began to lose the use of the index and middle fingers. When first seen on January 23rd, 1906, the hands were intensely cyanosed, and there was marked weakness of the movements of the whole of the left upper limb, especially of the fingers. There was no muscular wasting, but extreme spasticity of the wrist and fingers, with increased deep reflexes of the fingers, wrist, and elbow. Knee-jerks were equal and brisk. Pulses very feeble on both sides. There was no weakness of the legs or any abnormality, except that she complained of the left foot feeling colder. Sphincters normal. No headaches, optic neuritis, sickness, or any other intracranial symptom. Since January, 1906, the symptoms have slowly progressed, until in February, 1907, the left hand had lost all power of movement, with only slight movement of the elbow. In February, 1907, the first trace of involvement of the left leg appeared, transient weakness and dragging, with left knee-jerk +, but flexor plantar. In May, 1907, she dragged the left leg, and the left plantar was absent. Now, in October, 1907, there was permanent dragging of the left leg, and the left plantar was now extensor. There was never any trace of anæsthesia on the hand or foot, or any sign of intracranial lesion. The spine, neck, and thorax appear normal.

Dr. Parkes Weber had published a similar case Dr. Weber and Dr. Beevor thought the condition was one of progressive cerebral sclerosis.

Mr. Percy Sargent showed a case of

NERVE-ROOT GRAFTING.

Male, æt. 19. Shown by Dr. F. E. Batten, before the Neurological Society, in July, 1906, as a case of brachial plexus palsy, following influenza two months previously. Two weeks after the illness pain in right shoulder and arm. Power in right arm suddenly lost at this time. When admitted to hospital in June, 1906, there were weakness and wasting of deltoid, spinati, triceps, and biceps. An area of anæsthesia and analgesia over shoulder and outer side of upper arm. The fifth cervical root exposed and tested with faradic current. The root was split longitudinally into an upper part which alone gave feeble contractions of deltoid and spinati; and a lower, which gave contractions of biceps and supinator longus. The upper portion was divided and its peripheral end turned down and implanted into the sixth root. Three weeks later some affection, both sensory and motor, of the sixth root area, which passed off in two or three months. Now, fourteen months after operation, deltoid and spinati were much increased in bulk, and can be used voluntarily with considerable degree of power. Deltoid and spinati reacted to faradism.

Dr. Henry Head pointed out that the recovery was probably due to nature and not to the operation. The muscles were already improving when the operation was performed. Dr. Wilson, who had watched the case, said that the triceps and serratus magnus had equally improved in spite of no operative measures. Dr. Wilfred Harris related a similar case that had improved after operation.

Dr. Ernest Jones showed a case of

ISOLATED PARESIS OF RIGHT SERRATUS MAGNUS.

Male, æt. 4. Family history.—Negative. Previous history.—Mother discovered two years ago that right shoulder blade was prominent. No previous illness or accident. Present state.—Healthy boy, with no signs of diease except as follows: right scapula elevated, not tilted. Vertebral border and angle prominent at rest, but greatly more so on flexing shoulder joint. Protrusion of right upper limb weak; elevation above head fair. Serratus magnus not palpable.

Dr. C. E. Beevor said that the weakness of the serratus was incomplete, as elevation of the limb was possible. He considered that the condition was a congenital one.

Mr. Kilgour showed a case of

MUSCULAR ATROPHY WITH DELAYED THERMAL SENSATION.

Æt. 20. In February, 1906, first noticed slight wasting of hands. This had increased since. Previous to this had frequently blistered fingers while smoking cigarettes. Although no pain was felt at the actual moment of injury, a few seconds later a sensation, similar to that caused by a burn on any other part of body, was experienced. Present condition.—The hand muscles are atrophied, and react sluggishly to faradism. Skin of fingers glossy. No anæsthesia or analgesia. Over arms and upper part of chest heat and cold are frequently confused. There is delay of a few seconds before thermal stimulus is appreciated. This is best marked on hands. There is blunting to the faradic current over the dorsal and palmar surfaces of both hands, and along inner sides of forearms and upper arms. Over the ulnar sides of hands this amounts to anæsthesia. Scoliosis present.

Mr. Kilgour considered the case one of syringomyelia.

Dr. S. A. K. Wilson showed a case of

SEGMENTAL PAN-HYPERTROPHY.

Female, æt. 26. This congenital hypertrophy of certain parts of the body was as follows. At present the left arm was much larger than the right; the left thorax was rather larger than the right, and so was the left breast: the left leg was slightly larger than the right. The right foot and leg could not be considered normal, and the first two fingers of the right hand were larger in proportion than the others of that hand. The hypertrophy was a true one, affecting bones and soft tissues alike, and Dr. Wilson proposed the term "segmental pan-hypertrophy" for the condition. The telangiectatic and pigmented areas of the skin occurred generally.

Dr. Parkes Weber had collected the published cases of this condition recently, and recorded some of his own.

Dr. Farquhar Buzzard showed a case of

HUNTINGTON'S CHOREA.

Male, æt. 49. Healthy until two years ago, when he had a "nervous breakdown" lasting about two months, during which he had difficulty in speaking. Six months ago first noticed involuntary movements of the legs and trunk, associated with some pain in left leg and abdomen. Movements had continued with varying intensity. Latterly he has become stupid, memory failing and some depression. Present condition.—Choreic movements, affecting chiefly the trunk and large limb muscles. Some mental deterioration.

Dr. Buzzard also showed a case of

DISEASE OF THE CERVICAL VERTEBRÆ; WITH PRESSURE SYMPTOMS.

Girl, æt. 15. January, 1906. The neck gradually became stiff, and she noticed a small swelling about the size of a walnut, which was rather tender. In the course of two months she became unable to move her head at all, except slightly to flex it, and by June, 1906, the swelling had increased to its present size. At the end of 1906 came a gradual return of movement in the neck, and she has been able to move it more or less freely ever since. In March, 1907, the right arm began to feel numb and gradually weakened, and a week or two later the right leg began to drag.

For three months these limbs were more or less completely paralysed. In June there was retention of urine for three weeks. There was a large rounded, hard, painless swelling occupying the back of the neck below the level of the hairy scalp. This part of the neck was rigid, but the movements of the head were remarkably free. Strings of firm, discrete, slightly-swollen glands might be felt in the cervical triangles. The right arm was immobile at shoulder and elbow; the hand was of the *main-en-griffe* type. The left arm was rather weak, and there was slight wasting of the small muscles of the hand on this side. Both legs were weak, especially the right. There was a diminution of the sensation of pain in both legs, more on the right side, and in both arms, more on the right side. The deep reflexes were everywhere brisk, with double knee clonus, and a double extensor response.

Dr. **Henry Head**, Dr. **Wilson**, Dr. **Grainger Stewart**, and Mr. **Donald Armour** discussed the results of operative treatment of Pott's disease.

Dr. **James Taylor** showed a case of the Landouzy-Dejerin type of myopathy. The patient, a woman of 28, had first suffered from facial weakness, about eight years previously.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held October 18th, 1907.

Mr. R. Clement Lucas, F.R.C.S., in the Chair.

A paper on the SIMULATION OF SOME OF THE SYMPTOMS OF PRIMARY AMAUROTIC IDIOCY

by a tumour of the interpeduncular space, by Dr. E. C. Williams, of Bristol, was read. The patient was a girl, æt. 15 months. For three months she had been gradually failing to take notice of objects, and had been getting weaker. On admission she lay quite still and motionless, was somnolent, and not disturbed by any sounds, even though quite close to her ears. Her eyes were firmly closed, and when sat up in bed her head rolled either backwards or to one side. The arms were slighty spastic, the wrist-joint was flexed, and there were slight athetoid movements of the fingers. The legs were spastic, and remained extended when the patient was raised from the bed. The knee-jerks and plantar reflexes were exaggerated on admission, but towards the end the spasticity decreased and nearly disappeared. Babinski's sign was present; sensation was diminished. The pupils were dilated and fixed; the right was divergent. There were no fundal changes, the disc and macula both being normal. The child died 19 days after admission from œdema of the lungs and heart failure. *Post-mortem.*—A cauliflower growth the size of a walnut was found springing from the pituitary body; microscopical examination showed it to be a round-celled sarcoma. There was also a small similar growth in the parietal region. The case resembled primary amaurotic idiocy in the paralysis of the greater part of the body and the muscles of the neck, in the diminution of vision, leading to absolute blindness, and in the marasmus and fatal termination. It differed in that it did not present the characteristic fundal changes, and in its more rapid progress.

A case of *Associated Movements of the Upper Eyelid and Jaw* was shown by Mr. **Sydney Stephenson.** There was slight ptosis on the left side, and when the child moved the jaw the lid of the unaffected eye showed rhythmical movements upwards and downwards. An unusual feature in his case was that the movements affected the eye which had no ptosis. The explanation commonly received, assumed that the levator palpebræ superioris was not supplied entirely from the third nucleus, but also by fibres from the fifth nerve nucleus, so that when certain of the muscles of mastication were thrown into action, the upper eyelid participated in the movements of the jaw.

Mr. **Stephenson** also showed a case of *Tuberculosis of the Iris and Ciliary Body,* with reference to Calmette's ophthalmo-reaction. The eye had been inflamed for six months. The anterior chamber of the left eye was more or less filled with solid-looking yellowish-grey exudation, so that only a faint indication of the position of the pupil could be obtained. The eye was reddened, flushed easily, and dreaded the light somewhat.

A case of *Congenital Ptosis Treated by Motais's Operation of Tendon Transplantation,* very slightly modified, was also shown by Mr. **Stephenson.** The patient was a girl, æt. 2 years and 10 months. None of her nine brothers and sisters had any deformity. Family history unimportant. The left eye was the subject of incomplete ptosis, the pupil being practically covered by the drooping upper eyelid. There was no epicanthus, and no associated deformities. Upward movements of the eyeball were good, and no synkinetic movements were noted. The superior rectus was divided into two parts; the outer was stitched into the upper eyelid, and the knot tied on the skin surface of the latter. Seven days later the stitches were removed.

A case of *Lupus Vulgaris of the Face,* due to inoculation by a finger-nail, was shown by Mr. **George Pernet.** It was the result of an accidental scratch by another child.

The **Chairman** alluded to three cases which had been under his care. One man scraped his knuckle by striking a man in the mouth; another man was bitten on the forefinger; and the third case followed circumcision.

A case of *Multiple Lupus Vulgaris* following an attack of measles was also shown by Mr. **Pernet.** It had previously been brought before the Society by Dr. Poynton for lichen scrofulosorum.

The **Chairman** remarked that in many cases the disease was spread in the same person by scratching.

A case of *Generalised Alopecia* in a Mongolian idiot was brought forward by Mr. **Pernet** to demonstrate the good growth of hair on the scalp, as the result of persevering local treatment, and the exhibition of thyroid extract.

An unusual case of *Infantile Paralysis* was shown by Mr. **Lockhart Mummery.** The child, æt. 18 months, lost the use of all its limbs during an illness 12 months previously, though the arms were only slightly affected. Since then the child had recovered the use of the arms, but the flexor action of the fingers of the right hand was not quite normal. There was very slight extensor power in the right thigh, but none in the left limb. The adductors on both sides were completely paralysed.

A case of *Genu Recurvatum* was also shown by Mr. **Mummery.** The child, æt. 3 months, was born with legs bending the wrong way. Both legs were hyperextended to an angle of 30 degrees, and could not be flexed beyond a straight line.

A case of *Synostosis of the Upper Ends of the Radius and Ulna* was shown by Mr. **Hugh Lett.** Both arms were involved, and skiagrams showed that the radius and ulna were united by bone for about an inch at their upper ends. The right radius was much curved. The right arm was in a position of nearly complete pronation, the left arm midway between pronation and supination. Flexion and extension of the elbow joints were perfect.

The **Chairman** said that congenital ankylosis was very rare; some explanation such as intra-uterine fracture, or an arthritis very early in life, seemed necessary to account for the condition.

A case of *Osteogenesis Imperfecta* was shown by Dr. **Langmead.** The child was born after an easy labour seven weeks previously, and was brought to the hospital on account of the deformities four days later. The legs and thighs were sharply bent, the arms and forearms were also bent, but not so much. Amniotic dimples were seen on both legs, and on the right thigh. The post-anal dimple was well defined. Skiagrams showed fractures of the right humerus radius and ulna, of both tibiæ and fibulæ, and of each femur in two places, making eleven in all. There was marked callus formation about some of the fractures, especially those of the leg and thigh bones. The shadow given by the bones was no less dense than normal. There were nine other children in the family, all well, and there was no evidence or history of syphilis in the parents.

Mr. **Hugh Lett** alluded to a similar case he had brought before the Society last session, and asked whether there was any suggestion of heredity or sign of hydrocephalus in Dr. Langmead's case.

Dr. **Langmead** replied that there was no hydrocephalus or history of heredity.

A case of *Congenital Heart Disease* in a boy, æt. 5 years, was shown by Dr. C. W. **Chapman**. The only symptom he had had was some shortness of breath on exertion. He had had no illness beyond an occasional bronchial attack, one being so severe as to require confinement to the room for six months. He was exceptionally well developed, and his mental condition was beyond the average. The cardiac dulness was not increased. In the pulmonary area there was a harsh systolic murmur which was conducted upwards and outwards. Over the midsternum there was a loud, blowing systolic murmur which could be traced in all directions, and was faintly audible in the midscapular region. The aortic sounds were normal. There was no cyanosis, and the finger-tips were not clubbed. Dr. Chapman considered that the interventricular septum was patent, with stenosis of the pulmonary artery. The points of interest were the absence of usual symptoms (with the exception of shortness of breath on exertion), and the boy's excellent development.

Dr. **Carpenter** agreed with the diagnosis of congenital malformation of the heart and stenosis of the pulmonary artery. The murmur which was heard all over the front of the chest was better heard on the left than on the right, and it was also heard in the great vessels of the neck. When the murmur was so conducted, he looked upon it as a sign that the septum ventriculorum was perforate, but unfortunately it was not an infallible sign. He did not agree that there was no right-sided hypertrophy, and pointed out that an X-ray examination would determine the point. It was not uncommon for cases of congenital heart malformation to give no physical indications of their infirmity until an initial attack of bronchitis or broncho-pneumonia, from the onset of which, cyanosis and other signs often dated. Mild varieties of narrowing of the pulmonary artery, such as this appeared to be, were not incompatible with long life. The dangers lay in the balance of the circulation being upset by lung troubles, and by the onset of endocarditis further complicating matters.

Dr. **Cautley** remarked that the patient was a good illustration of the fact that in these cases the prognosis depended on the general health of the child and the circulatory effects, rather than on the loudness and distribution of the murmur.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Nov. 3rd, 1907.

Acute Œdema of the Lungs.

The treatment of acute œdema of the lungs must be prompt to be successful. The best authors (Hayem, Huchard, Dieulafoy) are agreed on the necessity of blood-letting whenever practicable. From 10 to 12 ounces of blood should be drawn, the procedure to be renewed the following day if necessary. Under its influence the threatened asphyxia disappears with rapidity. If for certain reasons general blood-letting is not accepted, or possible, wet cupping or leeches should be employed, although not to the same advantage.

Spartein or strophanthus is useful to strengthen the action of the heart; digitalis should be reserved for the sub-acute or chronic form depending on cardiac origin. Champagne might be freely given, while chloride of calcium has been recommended by Sztahovszky. Ipecacuanha is useful in œdema complicated wtih general bronchitis.

Oxygen gas may be respired with benefit. M. Huchard recommends injections of camphor and oil (1—10) and strychnine is very beneficial, and should be preferred to cafein. Morphia is absolutely counterindicated and dangerous. The same may be said of blisters. As to iodide of potassium, it should be suppressed as soon as the first symptoms of œdema set in.

In rheumatism complicated with pulmonary trouble, salicylate of methyl as an external application is dangerous, as it possesses marked œdematogenic properties.

Suppression of salt in food is absolutely indicated in acute œdema, as œdema is one of the consequences of the retention of chlorides.

Treatment of Hæmophilia.

At the recent meeting of the Congrès de Médecine, M. Carrière (Lille) read a paper on the treatment of hæmophilia. The patient should, if possible, be ordered a change of climate, either to the seaside or to the mountains, to renovate the blood. A tonic régime should be instituted (eggs, meat, vegetables), iron or arsenic is useful against anæmia, but has no direct action on the hæmophilia itself. For this, chloride of calcium, gelatine, serotherapy, constitute the most favourable treatment. Chloride of calcium might be given in 15gr. doses four times a day (adult), and continued for some time. Gelatine is less satisfactory. Serotherapy was recommended recently by Weill. An ounce of the serum of the horse might be injected every 10 or 15 days.

When an operation seems necessary on a patient suspected of hæmophilia (vegetations, amygdalotomy, avulsion of a tooth), the coagulation of the blood should be examined before operating, and the patient submitted to a preparatory treatment several days before the operation. Injection of an ounce of animal serum every day; enemas of half-an-ounce of gelatine three times a day; administration of a mixture, containing from one to two drachms of chloride of calcium.

In case of hæmorrhage, the usual local methods of arresting it, according to the region, should be employed; plugging for epistaxis, obliteration of the dental cavity with wax, after avulsion, etc.

The Continental Anglo-American Medical Society.

The annual meeting of this Society was held recently in Paris. Dr. Coldstream (of Florence) was in the chair, and the following members were present: Mr. G. H. Brandt and Dr. Egerton Brandt (Nice and Royat), Dr. Cormack (Vichy and Hyères), Dr. Cafferata (Spa), Dr. Douty (Cannes), Dr. Heinemann (Bad Nauheim), Dr. Johnston Lavis (Beaulieu), Dr. Trèvès-Barber (Geneva), Dr. Sillery Vale (Arcachon), Dr. Bull, Dr. Maguin, Dr. Gros, Dr. Jarvis, Dr. Rivière, Dr. Marucheau, Dr. Turner, Dr. Warden, and Dr. Leonard Robinson (Paris), hon. secretary.

After the presentation of the annual report it was announced that a brass tablet to the memory of the late Dr. Alan Herbert, Officier of the Légion d'honneur, had been erected to his memory by members of the Society in the chapel of the Hertford British Hospital, Paris.

On examination of the voting papers to fill the vacancies on the Executive Committee, it was found that Dr. G. Sandison Brock (Rome), Dr. Maguin, and Dr. Warden (Paris), and Dr. A. Hugh Gibbon (Naples) had been elected. The following five candidates for membership were duly elected: Frederik Michael Bishop, M.R.C.S., L.R.C.P. (Varenna 3, Cadenabbia); Marc de Levis, M.D.Lyons (Nice); Bryden Glendining, M.B., B.Ch.Durham (Madrid); Frederick Aylmer Hort, M.R.C.S., L.R.C.P., M.D. Montpellier (Nice and Aix-les-Bains); Arthur Gerald Welsford, M.D., B.C.Cantab, F.R.C.S.Eng., D.P.H. Cantab (Rome). There were no fewer than eight motions down on the business paper, but these were mostly withdrawn after full discussion. It was, however, generally considered that it would be an advantage to members of the Society and to the travelling public, if a list could be made as complete as possible by the inclusion in it of all duly qualified and eligible British and American practitioners on the Continent of Europe and North Africa. It was also decided "that no members shall be eligible to hold any office in the Society unless the full amount of his annual dues be paid." The motion that "five black balls shall be considered sufficient to exclude a candidate," gave rise to considerable discussion, but it was ultimately carried.

Dr. Heinemann said that as a result of the discussions on the various motions he proposed that the Society appoint an ethical committee; the proposal was seconded by Dr. Maguin, and will be discussed at the next annual meeting. A hearty vote of thanks to the Chairman brought the meeting to a close. In the evening the annual dinner of the Society was held at the Hotel du Palais D'Orsay, when twenty members of the Society were present, besides many guests, the gathering proving a most enjoyable function.

RONTGEN RAYS IN MALIGNANT TUMOURS.

The influence of X-rays in malignant tumours was set forth by Dr. Béclèse at the recent surgical congress. It is well-known that the neoplastic cells are more sensitive to the action of the rays than healthy cells; the former are destroyed while the latter resist. This properly explains the curative action of the rays which succeed very well in certain maladies, producing a complete cure; at other times the improvement is only temporary, and in many cases the effect is absolutely nil.

Complete cures are observed in cutaneous epithelioma provided it does not penetrate further than the skin.

Complete disappearance is also observed in certain tumours of the breast. The slow development of a neoplasm of the breast, when it is movable under the skin and well in front, has a chance of being cured by radiography. Even when the tumour is ulcerated superficially, and to more or less extent, success may be hoped for. Tumours of the breast that have returned after operation, under the form of indurated ganglions, limited to the cicatrices of the operation or in its immediate neighbourhood, easily disappear.

However, when the relapse attacks the deep tissues, the rays are without effect.

In epithelioma of the mucous membrane, the results are not satisfactory. Exception might be made, however, for epithelioma of the mucous membrane in continuity with skin and in the neighbourhood of the natural orifices; lips, arms, external genital organs, prepuce flaws, labii; neoplastic ulcerations of the lips have frequently disappeared as well as the submaxillary glands which accompanied it. A few isolated cases of cancer of the tongue have been cured, at least for a time, consequently radiotherapy should be tried, at least at the beginning when the surgeon hesitates to pronounce the word "operation." Later it will be simply a complement of the operation to destroy the visible or invisible germs which escaped the action of the knife.

In the treatment of sarcoma, for which the bistomy is given the first place, the rays complete the operation and prevent relapses more successfully than in other forms of cancer.

During the discussion which followed the statistics of 107 cases were examined: Cutaneous epithelioma furnished 23 cures out of 28 cases (82 per cent.); epithelioma of the mucous membrane, one temporary improvement out of 17 cases, in other words, completely unsuccessful; tumours of the breast: two small fibroma cured, 11 characterised cases of cancer, uninfluenced; 2 successful cases out of 7 relapsing cancers. Some sarcomata and osteo-sarcomata (five cases) notably improved.

To resume, the X-rays cure almost with certainty cutaneous epithelioma, improve sarcoma, and certain tumours of the breast, especially recent relapsing cancers, and fail completely in all other neoplasms. Nevertheless, the treatment, exercising a moral action, at least, can be employed with precaution in those cases where surgery has declared itself powerless.

GERMANY.

Berlin, Nov. 3rd, 1907.

IS OPIUM USEFUL OR HARMFUL IN ACUTE PERITONITIS?

THIS is an exceedingly important question discussed by Prof. Pel, of Amsterdam, in the *Berliner klin. Wochenschr.* (32/07).

He says that during the last few years many practitioners, especially those inclined to surgery, have objected to the employment of opium in acute perityphlitis, and have rejected it as unsuitable. And now matters have advanced so far that even physicians—Dieulafoy, of Paris, for example, Bourget, of Lausanne, Albu, of Berlin, and others—have ranged themselves as opponents of opium.

Although thoroughly convinced of the high importance of theoretical considerations and experiment, he takes his stand on this: that questions such as the above can only be solved by clinical observation at the bedside and experience. From observation of 30 cases the writer is convinced that opium should not be rejected in treatment of acute perityphlitis. He considers the useful influence of opium in this disease as one of the best founded facts in medicine. The injurious effects of vomiting on the heart and abdominal cavity are partly eliminated by it; the restfulness in bed, so urgently needed, is aided; rest at night is assured, and the tormenting feeling of thirst is diminished. The spasmodic peristaltic contractions which tear away adhesions and further the extension of the mischief are quietened, and the limitation or encapsulisation of the inflammatory process is assisted. Thus the healing art assists nature in its endeavours to limit the spread of the disease, and at the same time the humane aims of medicine are brought into play, and the three requirements of our wise forefathers of an ideal method of treatment—*tuto, cito, et jucunde*—receive their fulfilment.

The author gives the opium in the form of laudanum or tinct. opii, in doses of 10 or 15 drops every hour or every two hours, diminished as soon as the patient's condition will allow. With suitable applications of ice, small doses of opium will often answer the purpose. If the pain has to be mastered quickly, it will be proper to begin with a subcutaneous injection of morphia. Small rectal injections of a few drops of laudanum also act favourably. Moreover, the patients bear opium even in large doses remarkably well. Any possible constipation accompanying the opium is not a contra-indication. The writer has never seen any trace of intestinal paresis, meteorism, or abnormal decomposition of abdominal contents or absorption of intestinal poisons in consequence of the opium treatment. Neither can he agree with Albu's assertion that opium often leaves a tendency to constipation behind it. Not infrequently one gets the impression that, as in lead colic, opium has the effect of furthering intestinal evacuation by its anti-spasmodic powers. He is quite convinced that purgative treatment is the worst of all, that here it may be said, "*Qui purgat, male curat.*"

A second objection brought mainly by the surgeon against the use of opium in acute perityphlitis is that it "masks" symptoms. The author does not share even this view. The bowel is not paralysed (as believed by Albu) by the opium, but the undesired, irregular, and painful contractions are relieved by suitable—*i.e.*, therapeutic, non-poisonous doses of the drug. The subjective feeling of well-being is increased, the patient rests better, the vomiting becomes less tormenting, and, of course, the abdominal pain becomes less severe. He cannot understand how a "good" observer can be deceived if he watches all the symptoms of the disease (pulse, tongue, temperature, respirations, general condition, blood, urine, abdomen, etc). Such deception could only occur to one who was not a good clinical observer, or one who treats his patients with really poisonous doses of opium.

Naturally, absolute rest in bed, ice applications, and the strictest dieting are necessary. In the most acute cases in which the diagnosis is assured and the other conditions are favourable, the so-called early operation is rational and should be recommended during the first 24 or 36 hours. This method of treatment can scarcely be carried out in one-third or one-fourth of the cases. As soon as the general and local symptoms point to suppuration, the abscess should be opened, but this will only be in a comparatively small number of cases.

The writer thinks it a great pity that the general practitioner who has the great advantage of meeting all classes of cases, mild and severe, and in all stages from the earliest to the fully developed, should have taken so little part in the solution of this important problem, as they are in the best position to give a reliable opinion on the immediate and subsequent results of any method of treatment.

The author would lay down two propositions scarcely in accordance with the spirit of modern medicine, but in agreement with the words, *Vidi quid scripsi:*—

(1) With proper treatment, acute perityphlitis (appendicitis, periappendicitis) will run a favourable course in 90 per cent of the cases.

(2) The physician who treats his cases of perityphlitis on these principles by no means neglects them. The disadvantages of giving opium, and the advantages of a laxative line of treatment, are theoretical rather than based on accurate clinical observation. That physician who withholds opium in suitable doses from his cases of acute perityphlitis (exceptis excipiendis) is guilty of the sin of omission; he who treats them with laxatives, of malpraxis.

Amongst the numerous subjects discussed at the International Congress for Hygiene and Demography held in Berlin was that of the

ÆTIOLOGY OF TUBERCULOSIS.

Prof. Arloing, of Lyons, believed there was only one bacillus of the disease. The supposed different kinds or types were temporary varieties whose special forms lasted only as long as the circumstances that gave rise to them.

Strictly defined types were rarely found. The bacilli comprised an almost unlimited series of individuals whose forms gradually passed into each other. This changeableness sufficed to explain the usual distinguishing signs of tuberculosis in mammals and birds. Both from a medical and hygienic standpoint there was a real danger in laying down principles for the prevention of tuberculosis on such slight differences.

Dr. Ravenel, Philadelphia, said the digestive tract was frequently the point of entry of the bacillus. The bacillus could penetrate the uninjured mucous membrane of the intestines without causing any wound. This occurred mostly during the digestion of fatty foods. The bacilli passed with the chyle along the lymph tracts, and through the thoracic duct into the blood, which carried it into the lungs, where by the filtrating action of the lung tissue they were to a great extent retained. Infection through the digestive tract was particularly frequent in children. The milk of tuberculous cows was the cause in many cases.

The disease could be conveyed by touch, by kissing, unclean hands in cleaning up after cases of death, by the washing of vessels that had been used by tuberculous patients, etc. These kinds of infection, however, played only a subordinate rôle in the spread of the disease.

Hr. Flügge, Breslau, was of opinion that the disease was spread mostly by inhalation of tuberculous dust.

Prof. Ribbert, Bonn, concluded from the examination of cadavers that the disease was localized most frequently in the bronchial glands and in the lungs. In the majority of cases that in the glands was the only gland tuberculosis in the body. It could be of only aërogenous origin. Intestinal infection was of far less importance.

Prof. v. Schroetter, Vienna, said the lungs were most frequently the first affected.

Hr. Dieterlen said that if bacteria were injected into animals by the rectum they were found in the lungs four hours later. The germs ascended the intestinal tract, and passed into the lungs through the œsophagus. When the œsophagus was ligatured, they were never found in the lungs.

AUSTRIA.

Vienna, Nov. 3rd, 1907.

TUBERCULOSIS.

SCHRÖTTER had a paper on the necessity of notification in tuberculosis. This subject had been fully discussed at the International Conference, and a resolution passed (*a*) that all recognised cases of tuberculosis, (*b*) all dying of the malady, (*c*) and all removals of the disease should be carefully notified. He said (*a*) had been objected to on the ground of its scope; it is too extensive, and includes many cases not at all dangerous to the public, while (*b*) and (*c*) were accepted by both the International Congress and the Hague Committee. Now, if all cases be not notifiable, at what stage must we notify—those who are dangerous or those who are likely to become dangerous. We have often cases coming before us of such a light character that no notice is taken of them till they burst into a conflagration. We have often cases of local condition of the nose that end fatally in meningitis. These are cases equally as dangerous as if pleurites pneumothorax or other lung trouble had occurred. The social position is certainly one to be considered, where every care and cleanliness would be exercised.

All that authorities have to go on hitherto are the statistics of the dead, which must be accepted with some reserve, as many bronchitic, pleuritic, etc., cases may come under this category. This is now changed. There is no excuse for a false diagnosis with Pirquet's cutaneous or Calmette's ophthalmic test, which can be made in a few hours without any danger of injury to the patient.

It is not for us to point out the utilitarian side of the question to authorities, but it must be left in their hands, with the possibility of determining every case of this character within their area.

It is evident from our present knowledge of the disease that notification must come in its most comprehensive form, and that the more advanced cases must be isolated in sanatoria, or provided with hospital accommodation. When we examine the objections to notification we must admit they are weak and against the interest of the patient, but it must also be admitted that if such knowledge were made public it would injure many of the more healthy and less dangerous in their social and industrial life. It must not be forgotten that this information is confidential, and not for the public, although it is for the public good. If the subject affected be not dangerous, no particular notice would be taken, although the knowledge would be useful in important offices. It is interesting in this direction to read the accounts of Philip, Calmette, and Kayserling, of Norway, who have educated the authorities to take every care against the spread of this malignant disease. Here general notification is observed, and what is possible in this country can surely be carried out by other cultivated nations. It is important, however, that every effort should be made by the authorities for the proper treatment of every one so notified, and that reasonable regulations should be laid down for their observance. Raw, of Liverpool, advocated notification for the so-called severe cases which would be dangerous to the community. Milder or latent cases should not be pressed for notification. Obligatory notification existed in Sheffield on these lines, and appear to work satisfactorily. Glasenapp, Berlin, proposed an amendment that all cases dying from lung or throat tuberculosis should be notified, and the dwellings disinfected, and added that these diseases in life should be carefully observed. Teleky thought that obligatory notification of all cases of tuberculosis was impracticable, and would be resisted by the people. He thought a more obligatory disinfection of dwellings where advanced tuberculosis had been located, particularly in sanatoria or watering-places where lung diseases were treated, should be thoroughly supervised. Hermann, Prague, as a jurist, welcomed the general obligatory notification as a reasonable and effectual method of checking the diease. Every individual was a member of the State, and claimed its protection from infectious diseases such as tuberculosis and syphilis.

TUBERCULOSIS.

At the recent conference Flügge supported Weichselbaum in the belief of infecting by the bowel easier than the lung. The subcutaneous injection was no more potent than the inhalation, but acted quicker, while the alimentary canal conveyed a million times more bacilli than either of the other two portals. He admitted, however, that his experiments showed that fewer bacilli were taken in by the lung, but they acted more violently and virulently than inoculation or alimentation. But we must make an allowance for morals and customs when comparing animal experiments with human results. Children may be more easily infected by cheese, butter, milk, and unclean fingers, etc., than elderly persons, but the latter cannot escape the fomites or the organism in the dry dust from sputa, etc. The "Tröpfchen" or drop theory is quite plausible and possible. A patient suffering from the disease coughing causes the finer part of coughed matter to combine with the floating dust that is directly wafted to the healthy lung where it is deposited to germinate. This may be the mode of infection where long associations are kept up, such as between mother and son or man and wife, but in communities or large assemblies it is not so likely from the rapid oxidation in the fluid state weakening the potency of the virus.

HUNGARY.

Budapest, Nov. 3rd, 1907.

ACCORDING to the educational number of a leading medical weekly, the number of medical students has been increasing steadily since 1896. The University of Budapest had then about 500 students, whereas this this year it counts about 1,000. The standards of preparation of study and of graduation have been raised considerably, showing that there is a disposition on the part of all concerned to elevate the standard of the profession by bringing into it men and women who are better prepared to practice medicine, and who will be a credit to the profession in every way.

PUBLIC LECTURE ON SMALL-POX.

From the occasion of the small-pox epidemics in Vienna, Dr. Becsey gave a lecture to the lay people on the importance of second vaccination of adults. On the same day he discussed in the Medical Society the symptomatology and differential diagnosis of small-pox, and showed lantern slides made from photographs taken of patients at the Isolation Hospital. He also quoted the statistics of the Vienna Department of Health, showing the incidents and death-rate of the disease in vaccinated and unvaccinated persons, and described the methods of vaccination. He emphasised the necessity of using virus which was efficient. Failure to obtain a take was usually due to inert virus, and sometimes to improper technic in vaccinating.

SYMPTOMS OF HEREDITARY SYPHILIS.

Dr. Selley, in a lecture held at the Royal Medical Society's recent meeting, stated that in establishing a diagnosis of hereditary syphilis there were three points known as the triad of syphilis, which had long been looked upon as of the greatest value. These were Hutchinson's teeth, interstitial keratitis, and a particular form of deafness. These points were considered in their order. He reported several cases of late hereditary syphilis gleaned from the literature, and others that had occurred in his own practice.

AGGLUTINATION OF TYPHOID SERA.

Dr. Szèkacs has made the observation that the serum of patients suffering from typhoid will also agglutinate the paratyphoid germs, and it may be difficult to say whether the patient suffers from typhoid or paratyphoid. He pointed out the necessity of always determining the highest dilution in which agglutination will still take place. It may also happen that the typhoid bacillus will not be agglutinated by typhoid serum in low dilution; while with high dilution clumping will be perfect. In a case mentioned a dilution of 1 to 80 was tested against both typhoid and paratyphoid. The latter was clumped actively, the former not at all. A diagnosis of paratyphoid, therefore, seemed probable, yet, on further testing the serum, active agglutination was obtained with typhoid at 1 to 640; while the paratyphoid was not at all agglutinated in this dilution. The microscopic test is always more delicate than the macroscopic.

ON THE VALUE OF THEOPHYLLIN.

Dr. Kollarits analysed a series of 728 cases, which had been treated with theophyllin, with the following results:—In 326 cases the drug accomplished the desired effects; in 40 cases the improvement was only relative, and in 62 no good results were seen. In 85 patients theophyllin brought about a satisfactory diuresis after most other diuretics had failed, and in 55 diuresis was much more marked with theophyllin than with the other drugs. No difference in action could be detected between the pure drug and the various salts on the market. After effects were seen in as high as 31 per cent., but in the great majority these were very slight, and chiefly gastric (vomiting, diarrhœa and nausea). Two patients died soon after taking a powder, but it is impossible to decide if the latter was really responsible, since the cardiac weakness was extreme in each case. Collapse was observed three times, and in a large number such minor disturbances as languor, insomnia, and general nervousness. The best results were seen in cardiac hydrops, and (contrary to some observers) in acute nephritis; but good can also be accomplished in chronic nephritis, cirrhosis of the liver, and in exudative pleuritis. Often the first dose is not well borne, but a tolerance is soon established. At first no more than 0.1 grains should be given.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

TRAINING OF DEFECTIVE CHILDREN.—The first special school for the training of defective children in Edinburgh was opened on October 28th by Mrs. Burgwin, Superintendent of Special Schools under the London County Council. Mr. W. H. Mill, Chairman of the School Board, remarked that in Edinburgh they had been somewhat dilatory in providing a school of this kind, and they were indebted to Mr. J. W. Gulland, M.P., for having initiated the movement among them. In the school they intended to teach both mentally and physically defective children, and they had provided ambulance wagons to bring the scholars in the morning and take them home at night. They had two teachers, one trained to instruct mentally defective, and one trained to deal with the physically defective. A nurse would also be in attendance. Mrs. Burgwin, in the course of an interesting address, explained the methods adopted, and the class of children dealt with, in such schools. Imbeciles should be excluded. They would deal with those who manifested the first deviation from the normal—the child who could not read, but could sum, who had fits of temper, who was not quite right, but in regard to whom you could not say what was wrong. These children were very often nervous, untruthful, desirous of saying anything that would please, and dirty in their habits. In her own special schools many pupils who had seemed almost hopeless were now earning good wages; it was cheaper to spend money on schools than on penitentiaries and poor houses. She was almost hopeless about such cases when they reached adult life. The proportion of defective children was about 1 per cent., boys being more numerous than girls. In London about one-third of the children could always earn after leaving school; about one-third were doubtful. She advocated in connection with the least impressionable cases the establishment of good, bright, working colonies. A vote of thanks was moved by Dr. Clouston, and seconded by Mr. Leslie Mackenzie.

CARE OF FEEBLE-MINDED CHILDREN IN GLASGOW.—The first annual meeting of the Association for the Care of Defective Children was held on October 31st, Provost Bilsland in the chair. He moved a resolution commending the work of the institution to the public to obtain funds for the extension of the present institution at Kirkintilloch. At present only girls were dealt with, and the directors were most anxious to include boys. Sir John Tuke seconded, and spoke in terms of high praise of the management of the institution. Dr. John Macpherson, H.M. Commissioner on Lunacy, proposed a resolution recognizing that the work of the Association was much hampered by lack of statutory powers to retain feeble-minded children under its care against the wish of parents. He reminded his audience that the State was proverbially slow to interfere until philanthropic effort had paved the way for it, and that the whole of the great lunacy system of Scotland had been initiated by private enterprise and charity. Excellent as the work of the defective schools was, it did not protect the children or follow them through life as it ought. Perhaps when something like ample accommodation was found all over the country for feeble-minded children people would begin to talk about an increase of imbecility as they now did about an increase of insanity. At present they had no power to keep these children after a certain age, with the result that many of them at the most critical age of their lives went back to unsuitable guardians, and lost all the moral and physical good they had gained. In seconding the resolution, Miss K. V. Bannatyne pointed out that at present they had actually more power in the case of a normal child who lived in dangerous surroundings at home than they had in the case of the feeble-minded; it was necessary that the legislature should rectify this, and give them powers of compulsory detention.

Royal Medical Society.—The inaugural address of the 171st session of this ancient Society was delivered in their hall on October 24th by Professor Sherrington, Liverpool, who took as his subject "Inhibition." The lecture was illustrated by lantern slides, and was much appreciated. In replying to a vote of thanks, Professor Sherrington spoke of the extraordinary vitality of the Society—he thought it must be unique. In London there was the old Abernethian of St. Bartholomew's, but that, though more than 100 years old, was a mere youngster beside the Royal Medical Society.

Presentation to Dr. Carswell.—On October 24th the Lord Provost publicly presented Dr. John Carswell with a cheque for £415, and a silver salver bearing the following inscription, "Presented in token of their regard for his personal qualities, and in recognition of his services to the community, as a member of the Town Council and other philanthropic and public boards, and of his eminent services to the special department of medical practice to which he has devoted his life." Appropriate speeches were made by the Lord Provost, Sir John Batty Tuke, M.P., and Dr. Oswald.

St. Andrews University Rectorial Election.—Two nominations for the Lord Rectorship had been made, namely, Mr. Andrew Carnegie and Lord Avebury, and the poll had been arranged for November 2nd. On the day preceding the polling day, however, considerable surprise was occasioned by receipt of the intimation that Mr. Carnegie had declined to allow his name to go forward. Lord Avebury has therefore been returned unopposed. It should be stated that Mr. Carnegie had been nominated without his consent having been obtained.

BELFAST.

Visit of their Excellencies the Lord Lieutenant and Lady Aberdeen.—During the past week we have had a three days' visit from the Viceregal party, who spent a busy time in visiting various institutions in the city, and attending meetings. Lady Aberdeen was specially active in her interest in health affairs, addressing the opening meeting of the Belfast Branch of the Women's Health Association, speaking at a meeting of the Ulster Branch of the Irish Nurses' Association, and opening a bazaar for the Belfast Hospital for Sick Children. At the first-named meeting the chair was taken by the Lord Mayor, the Earl of Shaftesbury, and the attendance was very large and representative. Lady Aberdeen gave a stirring address on the problems of physical deterioration, and the awakening of the national conscience in health matters. She also put in a word for the Tuberculosis Exhibition shortly to visit Belfast. A resolution approving the formation of a local branch was moved by the Dowager Marchioness of Dufferin and Ava, who since her illustrious husband's death has lived at Clandeboye and interested herself deeply in local philanthropic movements. The High Sheriff, Dr. P. R. O'Connell, J.P., was able to speak with effect from his wide experience as a hospital surgeon in Belfast of the ravages of tuberculosis among the working classes of the city; and Dr. King-Kerr, J.P., the Chairman of the Public Health Committee, also spoke with local knowledge. A long and most successful meeting was brought to a conclusion by a vote of thanks to the Lord Mayor, moved by the Lord Lieutenant, and seconded by Sir John Byers, M.D. On Thursday afternoon Lady Aberdeen addressed a meeting of the Ulster Branch of the Irish Nurses' Association, which was presided over by Lady Hermione Blackwood, herself a trained nurse. Her Excellency appealed to the nurses to help in every way in their power towards the success of the Women's National Health Association, and pointed out to them how much benefit such an Association might confer on the community by dealing with such subjects as the provision of consumptive sanatoria and the regulation of food and milk supplies. In regard to the compulsory notification of consumption, she said that there were some things in the Act which would bear hardly on patients unless great care were exercised by the local authorities who put it in force, and it was thought better to have a short measure dealing with that class of case alone. The last visit paid by their Excellencies before leaving Belfast on Thursday was also one in the interests of public health, as it was to the Model Dairy established by Mr. Alec Wilson at Belvoir Park. The precautions taken to ensure the purity of the milk are as follows:—(1) The employees are inspected by a medical man, to ensure their being free from infectious disease; (2) The cows are systematically inspected by a veterinary surgeon, are properly housed, and are milked in the cleanest possible way; (3) The milk is at once chilled, to stop the growth of bacteria, then filtered through prepared cotton wool, bottled and sealed; (4) All utensils are properly washed and scalded with high-pressure steam immediately after use. Mr. Wilson contemplates the further step of testing all cows by the tuberculin test, if the public is willing to pay the higher price which this would render necessary, but at present the matter has not been settled.

Notification of Births.—At a meeting of the Public Health Committee held last week, the Medical Superintendent Officer of Health recommended bringing into operation the "Act to provide for the Early Notification of Births," and the Committee agreed to recommend the Corporation to do so. This will entail on all doctors and midwives who have seen a woman within six hours of her confinement the duty of sending information of the same to the Public Health authorities within 36 hours. For this work no remuneration will be given, though a supply of stamped postcards will be generously given to those who apply for them! No doubt the medical members of the Corporation will have something to say before the Act is finally adopted.

LETTERS TO THE EDITOR.

SOUTHEND AND CHELTENHAM.

To the Editor of The Medical Press and Circular.

Sir,—Southend and Cheltenham do not stand alone. The administration of sanitary laws throughout the country is everywhere more or less defective; in many places the laws are virtually almost completely ignored. This fact was illustrated within the past few weeks in the Local Government Board's report on 30 Lancashire boroughs and urban districts. In many of these places no medical officer is employed, and where a sanitary inspector is engaged he is often paid to devote only an insufficient part of his time to the work. Although overcrowded slum-dwellings are common, and outbreaks of infectious diseases frequent, no isolation accommodation is, as a rule, provided; whilst although the councils are largely made up of tradesmen, the Adulteration of Food Acts are mostly ignored. The offences of the Southend and Cheltenham authorities, in merely treating in the most scurvy fashion possible their medical officers, must be, in comparison, looked upon as quite venial. For all such offences the councils are held solely responsible. Over and over again, and as late as Tuesday, October 22nd, *The Times* (which, whatever its faults, remains still the great leading paper) has denounced local authorities in scathing terms. It charges them with "placidly obstructing, while the poor, who are unable to protect themselves, die of small-pox, of enteric fever, or of diphtheria; and while the children, whom it would be the first duty of a patriot, or of a statesman to protect, are left to waste their strength in struggles against preventible diseases which effective administration would speedily banish from the country." The main object of my letter now is to point out and emphasise the fact that if the direct blame may be fairly cast upon these inferior authorities the real blame and the greater shame rest upon the great body of citizens and ratepayers who put them in office or allow them to continue there when proved incompetent. No effective remedy for existing evils can be found unless the spirit of local and imperial patriotism can be roused. One would think this should be possible at least in a place like Cheltenham, a wealthy residential town, the seat of a great public school, and numbering among its citizens probably more capable men of leisure than are to be found in any other similar city of the same size. Even at places like Southend, which seem to exist mainly as cheap holiday resorts for Cockney trippers, it might be thought that the inhabitants would recognise their duty towards their town and their country. It might be thought they would recognise that the greater part of the misery due to sanitary maladministration falls upon the poor; that high infantile mortality is only a measure of the injury inflicted upon the survivors who struggle through, and that without an exuberant population, physically, mentally, and morally of the highest quality, the nation cannot prosper, the Empire cannot be maintained. Lastly, it is amazing to see the apathy of the responsible classes in face of a tremendously active socialistic propaganda that finds ample means at hand to stir the popular discontent in merely pointing to the evils which, owing to the selfish indifference of the wealthy, leisured, and cultivated classes, the poor are condemned, unheeded, to endure.

I am, Sir, yours truly,
SANITARIAN.

October 25th, 1907.

ADMINISTRATION OF ANÆSTHETICS FOR UNQUALIFIED DENTISTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—All who believe in protecting qualified practitioners in the exercise of their profession, and in protecting the public from the unqualified, must cordially approve of the exertions of the Irish Branch of the British Dental Association, to which you refer in an editorial note in your last issue. As you say, however, the practice is hardly of such important dimensions as the Association seems to imagine, and offenders can be easily dealt with by the General Medical Council or by the licensing bodies which have granted their qualifications. There seems, on the other hand, to be no protection either for the public or the medical profession against a practice more detrimental to the common good, and much more widespread. I mean the practice adopted by dentists, most of whom are not medical men, of themselves administering anæsthetics. Still worse is the custom, also stated to be widespread, of a mechanical assistant administering the anæsthetic, while his principal operates. Nowadays it is very rightly pointed out that even medical men are hardly sufficiently trained in the administration of anæsthetics; nevertheless, dentists and their unqualified assistants, without any training whatever, are willing to take the responsibility from which some qualified medical men will shrink. The large number of deaths which take place in the dentist's chairs is sufficient justification from the public point of view for calling attention forcibly to the matter. It should be penal by law for anyone but a qualified medical man to administer an anæsthetic. The British Dental Association might make a start by forbidding it to any of their members who are not medical men.

I am, Sir, yours truly,
CRITICUS.

VIVISECTION COMMISSION DIFFICULTY.—"KILKENNY CATS."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am interested to read your opinion that a committee composed of "Mr. Coleridge, Miss Lind-af-Hageby, Miss Beatrice Kidd, and Dr. Hadwen" would, after sitting a month, end in a tragedy similar to that of the Kilkenny cats. If your assumption were true, it might be in the best interests of the vivisectors to appoint such a committee, as it would furnish a short and easy method of getting rid of us. However, why the three last named should be groundlessly accused of mutual animosity absolutely passes my comprehension. May I explain that in the anti-vivisection world there is but one division—that between the abolitionists and the restrictionists, the latter party being represented by Mr. Coleridge. As this gentleman has informed the Royal Commissioners that he "wishes to secure the continuance of research," and "trusts that nothing will be done to hamper the legitimate employment of the method," he can hardly be called an anti-vivisectionist at all, therefore we have, on the side of the anti-vivisectionists, a happy family party remaining; and if the methods of the Kilkenny cats be adopted by those outside our circle, we are not concerned. Real anti-vivisectionists, I need hardly say, would not consider an increase of the inspectorate as any safeguard to vivisected animals. They remember the late Professor Lawson Tait's earnest warning, which history has so amply justified —"Combine to abolish the medical inspector." The vivisectors and Mr. Coleridge might welcome such a change; anti-vivisectionists would not, or would they regard it in the light of a "concession" to their demands.

Yours, etc.,
BEATRICE E. KIDD,
Secretary British Union for Abolition of Vivisection.

November 2nd, 1907.

A QUESTION OF PROFESSIONAL ETIQUETTE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I should be glad to have your opinion on the ethical aspect of the following announcement which appeared under the heading of "Court News" in the *Times* of October 24th, 1907:—

"Dr. J. Leon Williams, who has recently been made a Membre Honoraire of the Société Odontologique de France, 'en reconnaissance des éminents services rendus par lui à la Science Odontologique,' has returned to 30, George Street, Hanover Square, after several months' absence, in greatly improved health."

According to the latest *Dentists' Register*, this gentleman is an L.D.S.I.

Yours, etc.,
ENQUIRER.

[In reply to the inquiry of our correspondent as to the ethical aspect of this announcement, our opinion would depend on the way the announcement was brought about. The gentleman referred to may be the victim of journalistic officiousness. If, however, done with his knowledge, it is unquestionably a form of advertisement to be deprecated.—ED. M. P. AND C.]

WE are asked to announce that a Conference of Representatives of Sanitary Authorities will be held in the Council Chamber, Caxton Hall, Westminster, at 11 a.m. on Friday, Nov. 15th, for the purpose of considering the question of the establishment of a Supreme National Health Authority. Already the responses to the invitation to the Conference have been numerous and cordial, and the meeting promises to be a great success.

SPECIAL ARTICLE.

ANNUAL REPORT OF THE ROYAL COLLEGE OF SURGEONS, ENGLAND.

THE annual report of the Council has been sent to those Fellows and Members whose names are enrolled on the list of those to whom the report is sent annually. Any Fellow or Member may have the report sent each year from the College by applying to the Secretary. The report will be laid before the annual meeting of Fellows and Members at the College on Thursday, November 21st, at three o'clock p.m.

Direct Representation.—The question of direct representation of Members on the College Council is fully dealt with in the report, and includes the memorial of the Society of Members to the Prime Minister, together with the observations thereon by the Council of the College. The rejoinder to these observations by the memorialists is also published, and a statement by the deputation of Members of the College Council, together with some additional remarks made by the deputation when it was received by the Lord President of the Privy Council.

The question of admitting women is also dealt with, and the petition, having 2,792 signatures in reference thereto, is included. Counsel's opinion has been obtained on the points raised by the petitioners, and it has been ascertained, (*a*) that the Council have no power under the charters of the College to admit women to examination for the diplomas of the College, but that they have that power under the Medical Act of 1876; (*b*) that the Council can, if they think fit, admit women to examination for the diploma of Member, and decline to admit them to examination for the diploma of Fellow; (*c*) that a woman, admitted a Fellow or Member under the Act of 1876, would not be able to take any part in the government, management, or proceedings of the College by reason of obtaining a registrable qualification under the terms of the Act. Having satisfied themselves upon these points, the Council adopted the following resolution: "That, in the opinion of the Council, it is desirable that women be admitted to examination for the diploma of member." It was decided that, before taking a poll of the Fellows and Members upon the question, the Royal College of Physicians should be approached, in order that it might be ascertained whether that College would be willing to admit women to the Conjoint Examinations. Communications upon the subject have accordingly been addressed to the Royal College of Physicians, but their final reply has not at present been received.

Appointment of Assessors.—The Royal Colleges recently expressed their willingness to appoint assessors to the examinations conducted by the London School of Tropical Medicine, of students who have followed there or elsewhere a course of instruction approved by the two Colleges, and to grant to such candidates as may hold the diplomas of the Royal Colleges, and who are approved by the examiners, certificates endorsed by the aforesaid assessors. In pursuance of this scheme, Dr. H. H. Tooth, C.M.G., and Mr. A. G. R. Foulerton have been appointed assessors for the year ending June, 1908.

Vivisection.—The College having been offered the opportunity of giving evidence before the Royal Commission on Vivisection, the president, Mr. Henry Morris, was appointed by the Council to appear before the Commissioners as the College representative. The president gave his evidence in May last. The Council at the same time expressed the opinion that the Act of 1876 was sufficient protection against any abuse of vivisection, and "earnestly hoped that the progress of surgical science would not be hindered by further restrictive legislation."

Miscellaneous Items.—The number of diplomas issued during the period with which the report deals is as follows: Membership, 435; fellowship, 49; licence in dental surgery, 76; and the diploma in public health, 25. The attendance of members of the Council at the various committees held at the College during the past year is included, and it is interesting to notice that the president and vice-presidents were summoned to no fewer than 69 meetings, besides the usual monthly Council meetings. Extensive and valuable additions to the series of tumours of the brain have been presented to the college museum by Mr. C. F. Beadles, and a series of specimens from the same donor illustrating aberrations in the distribution of the cerebral arteries. Many valuable preparations of the viscera of the Port Jackson shark have been made from material presented by the Government of New South Wales and by Professor J. P. Hill. During the past collegiate year the supply of books and journals in the library has been well kept up, and the number for this period has been 11,090. The College obituary list includes 3 honorary fellows, 25 fellows, and 292 members.

THE PROPOSED MEDICAL SERVICE FOR THE TERRITORIAL FORCE.

SIR ALFRED KEOGH, Director-General of the Royal Army Medical Corps, addressed a meeting of the medical profession in Manchester during the past week, and explained at length the nature of the War Office's proposals for the medical arrangement of the Territorial Force. He said that the scheme which he was to explain was not by any means new, seeing that it was drawn up about at the time when he became Director-General, but had been held in abeyance till Mr. Haldane had considered the general arrangements for the organisation of the Volunteers. The medical service of the Volunteers, he remarked, was utterly inadequate either under the territorial army system or under the Volunteer system to perform the duties which are required of it in time of war. He knew that a great many people say, "Oh, when war breaks out you will get lots of doctors" but "lots of doctors" won't do. There is a differentiated function for the Army medical officer. He has not only to see to the curing of disease and the healing of wounds, but he is an administrator and organiser, and the better business man he is the better officer he is. All these things are compatible with a very definite love for and pride in his profession. He explained that when war broke out, what Mr. Haldane described as the expeditionary force would be able to leave the country, taking the regular medical service with it. The defence of England would then rest with the territorial force, and the medical equipment of this defence would fall on the medical profession. The duty of the medical profession in connection with an army was to maintain the strength of the fighting force in the field. That was the primary, almost the only, duty, because it included all the minor duties. In one year the strength of an army in the field diminished by 80 per cent. A large part of that diminution was due to disease, and it was the business of the medical service to see that disease was prevented and to see that no one was allowed to leave the force unless there was the strongest possible reason for his going. If the medical service determined that 3,000 or 4,000 or 5,000 men must leave the fighting area no one could say "Nay," so that such decisions entailed an enormous responsibility. In the field ambulances there was something entirely new in the British Army, but something that had proved a great success in the Russo-Japanese war. From the time that wounded men were picked up and taken to the field ambulance they would remain in charge of the medical staff; they were received, clothed, fed, paid, and where necessary sent home to England by the medical staff. This meant that an enormous work fell upon the medical profession. In an army of 100,000 men there would be always about 10,000 in the custody of the medical department. These 10,000 would have to be rigorously scrutinised as to the absolute necessity of their being transported home. One of the failures of the South African war was that many men came home to England who never should have come. In every one of the hospitals under the new scheme each patient would be watched carefully and sent back to his battalion if possible. Another new feature of the scheme was the provision of a sanitary service for an army in the field. Each division would have its special sanitary department under the charge of an officer with special knowledge of sanitation—a man whose whole time was given to sanitation in peace and in war, and whose business it was to see that the health of the troops was guarded. A school of sanitation had been established at Aldershot where men were being carefully taught for every battalion. At the manœuvres these men had had further experience of the work expected of them, and he was glad that reports received from the manœuvre areas were very satisfactory; in time of war he would like to flood the Army with military and civil sanitarians, and endeavour to prevent the decimation of battalions by disease. Turning next to the Volunteer army, he said the territorial scheme was a scientific scheme, and would, he hoped, effectually grapple with the deficiencies and anomalies of the now defunct volunteer medical system. We must, remarked the Director-General, have some arrangement by which the medical profession can devise a system of disease prevention, hospital organisation, and so on. He recognised that the medical profession is in a position of special difficulty with regard to volunteering. Under the old system the medical man had to go into camp every year, had to go through a certain course of instruction, and so forth. He held that it is only necessary for people to go into camp to undergo any training in peace who do not in civil life perform those duties which they would be required to perform in connection with the volunteer army. Surely the medical officer of health of a county or great town can learn nothing from us in time of peace concerning sanitation. These men should not have been excluded from the volunteer army; there should have been a place for them, some method by which the country could have the great benefit of their service and experience, without putting any burden upon them in time of peace. That is one of the principles he desired to lay down. But, of course, there are certain duties to be performed by medical men who join certain branches of the medical corps in connection with ambulances and hospitals which must be learned. Sir Alfred went on to explain that he proposed two medical officers for each volunteer battalion and that each officer should go into camp every two years. Even there, he said, I do not wish to impose difficult conditions. I say that even if the officer cannot go into camp in the year when it comes to his turn he need not. The conditions are such that his explanation of inability to attend would be accepted; but he would be asked to do something else—to assist in some way in furthering the volunteer movement in his own time during the year that would be left to his own good faith. In further explanation, he said that he proposed a consolidated medical corps for the territorial force, which meant that the medical profession would combine in one great organisation for the two classes of work which he had outlined—viz., hospital work and sanitary work—that the organisation should be an exact reflection of the medical corps of the regular Army, with a principal medical officer in each area derived from the volunteer medical service, that a staff officer should be selected from the Royal Army Medical Corps to assist the principal medical officer, and that at the headquarters of each "area" a military medical school should be established with a specially appointed adjutant and staff of instructors. At these schools officers could gain their certificates and be saved the time and trouble of journeys to Aldershot. We have, he said, no hospitals of any kind in the Volunteers, and I wish, in accordance with the principles I have enumerated, to raise the staffs of those hospitals in time of peace. I ask that the great physicians and surgeons in centres like Manchester and Liverpool should join the territorial force, not to undertake any duties whatever in time of peace, but to undertake specific duties in time of war. I do not ask them to leave their own towns. The principle here would be of sending sick and wounded to the hospitals. I propose to establish in connection with Manchester a large general hospital—a military territorial army hospital—which in time of war would work in conjunction with the troops in the neighbourhood. They could do this work without interfering with their private work or their work in hospitals. Sir Alfred added in conclusion, that the appeal which he made to the surgeons and physicians he extended also to the sanitarians of the country—the medical officers of towns and counties. He wanted a sanitary officer for each division in time of war. He was also hoping to raise a nursing service, and had already received much encouragement from the matrons of hospitals.

A cordial vote of thanks to the Director-General concluded the proceedings.

REVIEWS OF BOOKS.

POST-GRADUATE STUDIES. (a)

This collection consists mainly of papers read by the author at various medical meetings. He has been led to publish them in book form because he believes the subjects dealt with may prove of interest and service to a wider circle. The volume contains altogether nine clinical dissertations. Most of these deal with questions of diagnosis such as that of subphrenic abscess, pleural effusion, disseminated sclerosis, cerebral hæmorrhage, and acute endocarditis. One very interesting and instructive paper is that dealing with the naked eye examination of the fæces as an aid in the diagnosis of disease. It is, as the author remarks, too often neglected by the medical attendant. He tells of two cases, one a club patient who has run to earth by having his stools examined when they were found to be normal; and the other who was found to be suffering from malignant disease of the rectum. The author treats the subject under four distinct headings, viz., the amount, the colour, the consistence and general characters, and lastly the presence of abnormal constituents.

The last paper in the book is on the subject of syphilis in the Army. This gives a very exhaustive account of the matter, and is fully illustrated by means of several carefully compiled charts. Incidentally, however, we do not think so many charts should have been included as they tend to swell out the volume to almost one half the size covered by the text proper. The treatment of syphilis as it occurs amongst soldiers is very fully given, and is largely based on Mr. Alfred Cooper's ideas as set forth in the latter's work on this disease. The tables given will be found very useful for reference and comparison.

With regard to the other papers we need not enter into details. They have all of them reference to subjects of every-day practical importance, and will be of the greatest help to the busy practitioner who is on the outlook for fresh knowledge regarding the diseases of which they treat. Such a volume as this forms an excellent supplement to the ordinary textbooks of medicine, and for this reason we congratulate the author on its publication. The style is distinctly interesting and free from technical phraseology, so that the volume forms quite pleasant as well as instructive reading. It will doubtless find a place among the ever-increasing works and monographs on medical subjects. It is certainly well worthy of careful perusal by all who are seekers after knowledge.

WHAT TO DO IN CASES OF POISONING. (b)

No words of ours are required to commend this well-known pocket guide. It has been thoroughly revised, restored, and renovated, to use the author's own facetious language. A great deal of new matter has been introduced into this, the tenth edition. Dr. Murrell's name has become known to every student and practitioner of medicine through this excellent little treatise, without which we doubt if we should be able to cope with poisoning cases so well as we do. The author is witty and sarcastic at the same time, and his ready wit makes his remarks strike home in a way which few writers can achieve.

(a) "Post-Graduate Clinical Studies for the General Practitioner; First Series." By H. Harold Scott, M.D.Lond., M.R.C.S., L.R.C.P. Fellow of the Royal Institute of Public Health, late Medical Officer in charge of Hospital for Women and Children, etc. London: H. K. Lewis. 1907. Demy 8vo. Price 8s.

(b) "What to do in Cases of Poisoning." By William Murrell, M.D., F.R.C.P., Physician to the Westminster Hospital, Tenth edition. London: H. K. Lewis.

The various poisons are arranged alphabetically so that reference is quite an easy matter. It is quite interesting to find antipyrin and many other drugs, all of which can now be readily got in tablet form, referred to as being distinctly dangerous and very often giving rise to symptoms of poisoning when taken indiscriminately by the ignorant public. Thus sulphonal, veronal, and substances of a similar nature, in these days frequently used by laymen without medical advice, are mentioned as being poisons. The perusal of Dr. Murrell's book would doubtless terrify the drug-taker, while it should teach the general practitioners the dangers of administering drugs in tablet form. This edition is sure to be as popular as its predecessors. It is certainly very comprehensive and accurate in detail.

ON DIAGNOSIS IN URINARY SURGERY. (*a*)

"This little book describes the principal modern methods of localising and distinguishing those diseases of the urinary organs which are usually assigned to the surgeon." Perhaps the author will forgive us if we suggest that this sentence does not exactly convey his meaning, and that if the word "patient" was substituted for "surgeon" the sentence would be more gramatically correct.

The little work consists of four chapters. The first deals with the interpretation of urinary symptoms; the second with abnormal conditions of the urine; the third with the physical examination of the patient and of the urinary organs; and the fourth with the differential collection of specimens of urine. A curious point about the last chapter is that, though Nitze's inspection cystoscope is described fully in the previous chapter, in this one, which deals with the differential collection of urine, there is no mention made of Nitze's combined cystoscope and ureteral catheter. This instrument is, however, very much the easiest means of obtaining specimens of the urine from each kidney separately, and is far more exact than is Luy's segregator.

The book, however, gives, on the whole, an excellent introductory description of several methods of diagnosis in urinary surgery.

ON PRESCRIPTION WRITING. (*b*)

This is a most concise little work on prescription writing, and fully justifies its existence. Although it is short, it is most complete, and will be found invaluable to the student—in America. Unfortunately for the English student, the book is based on the American Pharmacopœia, and so, as far as dosage is concerned, would lead to confusion.

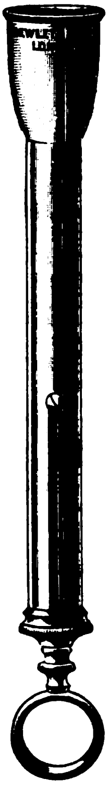
There is a handy list of mis-pronunciations of common occurrence, and also a list showing the pronunciation of pharmacopœial terms. So far as we have examined it, we have only noticed one mistake. Surely the pronunciation of cochleáre is as we have marked it, and not as Dr. Mann would have it—cochléare.

THE LAWS OF HEALTH. (*c*)

Hygiene as it affects the school child is a very complex subject, including, as it does, so many sciences of diverse characters. It is now universally recognised that the school teacher should be acquainted with the rudiments of the subject, and for the purposes of a text-book for such the volume under consideration is to be commended. The author is extremely well acquainted with his subject, and has shown excellent judgment in his selection of the matter incorporated, so that the teacher is provided with essential information. Particular mention must be made of the chapter on Physical Exercises, which includes a short dissertation on the anatomical principles underlying them, while that on Corporal Punishment is by no means the least important. We agree with the author that chastisement should only be administered for the graver faults, and for this purpose the instruments least likely to injure the offender are stated to be the birch and the tawse. Altogether the book is admirable, and can with propriety be commended not only to teachers but also to medical practitioners, who will find in these pages much useful matter.

NEW SURGICAL APPLIANCE.

NEW CUPPING INSTRUMENT FOR CERVIX UTERI.



The illustration represents a simple instrument designed by me, and neatly made by Messrs. Hewlett and Son, Charlotte Street, E.C. I find it useful for dry or wet cupping of the uterus, and by the latter proceeding I have been able to give speedy relief to the vertical headache so often complained of by women during the menopause. It will also remove unhealthy secretions from cervical canal in conjunction with the use of my wire curette, and thus prepare the part for the usual application of liquid escharotics or astringents, hastening the cure considerably in cases of chronic endometritis, etc. It will also be found useful during the operation for supra-vaginal amputation by drawing down the cervix, where the parts may be too soft and friable to be held by volsella. The cup is simply pressed well up on cervix, the central rod drawn down, and a half-turn of ring at base will throw projecting pin into angle of slot, and procure the vacuum in cup. This can be left on as long as required. The simplicity and handiness of the cervical cupper should, I think, recommend it for the purposes named, but no doubt many others will be suggested to the gynæcologist.

Alexander Duke.

MEDICAL NEWS IN BRIEF

Engineer's Death.—Conflict of Medical Evidence.

On the 10th ult., at the North Shields County Court, Elizabeth Davison claimed from Richard Irvin, steam trawler owner, £300 compensation for the loss of her husband, John Davison, an engineer on board the steam trawler Mercia, who died at sea on July 14th. Davison, counsel explained, was 34 years of age, and left five children, the oldest of whom was 11. While the vessel was off St. Abb's Head on July 14th he was found at the foot of the engine-room ladder in a dying condition. He had previously suffered from epilepsy, and had been operated on for that, but Mr. Morgan claimed that death was the result of an accident. Dr. Mears, who had known Davison for seven or eight years, spoke to performing the operation of trepanning for epilepsy on May 20th last, and to certifying him as fit to follow his employment on July 6th. He also described the post-mortem examination, saying that there was a large bruise about the size of a saucer on the top of the head, the scalp being knocked into a pulp. He gave his opinion that death was due to concussion of the brain or shock to the nervous system, caused by a fall down the ladder. There was, however, he admitted, no visible injury to the brain or skull, and no hæmorrhage.—Dr. J. H. Hunter, assistant surgeon at the Ingham Infirmary, South Shields, also agreed that concussion might have been caused without any visible injury to the brain, and this view was supported by Dr. Gowans, South

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(*a*) "Modern Methods of Diagnosis in Urinary Surgery." By Edward Deanesley, M.D., B.Sc.Lond., F.R.C.S., Hon. Surgeon Wolverhampton and Staffordshire General Hospital. Pp. vi. and 97. London: H. K. Lewis. 1907.

(*b*) "A Manual of Prescription Writing." By Mathew Mann, A.M., M.D., Professor of Obstetrics in the University of Buffalo. Revised by Edward Cox Mann, M.D. Sixth edition. Pp. 232. Putnam's, The Knickerbocker Press. 1907.

(*c*) "A Handbook on School Hygiene." By Carstairs C. Douglas, M.D., D.Sc. (Public Health), F.R.S.E. Pp. 240 and vii, with 72 illustrations. London: Blackie and Sons, Ltd. 1907. Price 3s. net.

Shields. For the respondent, however, Dr. Lochland Frazer, of North Shields, who conducted the post-portem examination, said death was obviously due to natural causes. There was no fracture of the skull, no hæmorrhage of the brain, and no laceration of the base of the skull, but the aortic valve was incompetent owing to the heart being dilated. Death was either due to epilepsy or heart failure.—Dr. Morrison, senior surgeon at the Royal Infirmary, Newcastle, expressed the opinion from hearing the evidence that death had resulted from nothing but natural causes. If death was due to concussion there would be a bruise on the brain.—Summing up, the judge commented on the difficulty of arriving at any facts at all. The only undoubted fact was that Dr. Frazer found in the post-mortem examination what he said was amply sufficient to cause death. There was no evidence that the heart affection was accelerated by the fall, and he gave his award for the respondent.

Unregistered Dentists Fined.

AT Old Street, prosecutions by the London and County Medical Protection Society (Limited) brought before the Court three persons—H. M. Hanreek, Bethnal Green Road; Joseph Lechan, Whitechapel Road; and Joseph Weinberg, Whitechapel Road—for contravening the Medical Act, 1878, by using styles and titles implying that they were registered dental practitioners under the Act. Mr. G. H. Young prosecuted; and evidence was given by Mr. Hugh Woods, M.D., Secretary of the prosecuting society, Craven Street, Strand, as to visiting the business premises of the respective defendants. Mr. Hanreek exhibited at his shop, which was also a hairdresser's shop, the name "H. Hanreek, surgeon dentist," above the door, and inside "G. Hanreek, practical dentist." The defendant Lechan, who is also a chemist, exhibited the words "surgeon dentist"; but Weinberg only exhibited a frame with the word "dentist" and a mass of teeth in the window. Mr. Percy Robinson, defending Hanreek, said the signs were put in in the time of his client's father, who was a registered dentist, and they had been left since his death in 1889. He had no idea he was infringing the Act. The defendant Lechan, defending himself, said he was qualified in Vienna and Berlin, and thought the qualifications were sufficient in England. Mr. A. J. David, defending Weinberg, submitted that the use of the word "dentist" alone was not any claim to be a registered dentist. Mr. Cluer overruled the point. He fined the defendants Hanreek and Lechan each the full penalty of £20 under the Act, and further to pay each three guineas costs. In consideration of the defendant Weinberg's having been carrying on his business since 1872, before the passing of the Medical Act, the magistrate imposed half the fine, £10, with three guineas costs.

Bogus Dentists in Ireland.

THE campaign started by the Irish Dental Association against bogus "dentists" has resulted in the case of the Attorney-General, at the relation of Kevin E. O'Duffy v. Henry J. Bradlaw, surgeon dentist, Limited, and eight other defendants, which was concluded during the past week in the Dublin Courts. The relator asked for an injunction restraining the defendant company, who carried on business in Dublin, from advertising for custom under the description of "surgeon dentist" or any other description calculated to induce the public to believe that such business was carried on by duly registered dentists. The defendants denied any conspiracy to deceive the public in the formation of the company, and stated that seven of the defendants, who signed the articles of association, were all, at the date of registration, registered as dentists under the Dentists' Act, 1898. They also denied that any wrong had been committed on the public. Since the action was instituted the defendant company had changed their trade name to that of "Henry J. Bradlaw, Limited." The Master of the Rolls, in giving judgment, said that all the time the action was instituted the directors and shareholders of the defendant company were, as stated by an eminent judge in another case, an audacious fraud upon the public. The names and style and title of the company was a false representation, and was scattered broadcast through the land. It was not necessary for the relator to prove that anyone incurred loss. Mr. Bradlaw might be an excellent worker—as good, perhaps, as any medical practioner, who had not been instructed in dentistry—but the Act of Parliament was clear on the point as to his right to describe himself as a surgeon dentist. He granted the injunction asked for, restraining the defendant company from describing their business in such a way as to lead the public to believe that their business was carried on by a person, or persons, registered under the Dentists' Act, 1898. He also granted an injunction, restraining the defendant company and its members from using the title dentist, either alone or in combination with any other word or words in the memorandum of association, or any returns or documents filed pursuant to the Companies Acts, with the Registrar of Joint Stock Companies.

Royal College of Physicians of London.

AT the ordinary quarterly *Comitia* of the College, held on Thursday last, Daniel Colquhoun, M.D.Lond., of Dunedin, New Zealand, and Edward Rennie, M.D.Lond., of Sydney, Australia, were admitted, *in absentia*, to the Fellowship. Dr. F. W. Andrewes was elected a member of the executive committee of the Imperial Cancer Research Fund, *vice* Sir William Broadbent, deceased. Dr. Frederick Taylor was re-elected a member of the Committee of Management of the Examining Board in England. W. H. Price Saunders, late a student of Epsom College, was, on the recommendation of the Presidents of the two colleges, appointed Jenks Memorial Scholar.

Medical Man Accidentally Shot.

WE regret to announce that Dr. Vining Paul, a young Harwich medical man, was the victim of a curious fatal shooting accident at Ramsey, near Harwich, recently. He had been rabbit shooting with some friends, and, the sport having finished, the guns were placed in a motor car in readiness for the return journey. By some mischance one of them was left loaded and cocked, and, just as Mr. Paul was stepping into the motor-car, a dog jumped and touched the trigger. The charge entered Dr. Paul's body, passing through the left lung, and he died on Friday evening. Dr. Paul, who was only 28 years old, came to Harwich in January of the present year, and had previously held an appointment at Taunton Hospital.

Royal Army Medical Corps.

MAJOR H. S. PEEKE has been granted six months' leave out of India on medical certificate.—Captain F. A. Stephens has assumed medical charge of Staff and Departments, Scottish Command, vice Captain V. J. Crawford, transferred to the Southern Command. —Lieut. J. A. B. Sim assumed charge of the Military Hospital, Berwick-on-Tweed, on the 1st inst., vice Captain F. M'Lennan, who takes charge of the Military Hospital, Aberdeen, during the absence on leave of Major A. O. C. Watson.

The Royal University of Ireland.

AT a meeting of the Senate of this University held on Thursday, October 31st, the following resolution was passed by a majority:—"That it is expedient for many reasons that the conferring of degrees in this University should be confined to the purely Academical Ceremonial, as it is in the University of Dublin and elsewhere." Presumably as a result of this resolution, the National Anthem was omitted from its usual place at the termination of the Degree-giving Ceremonial, which was held the following day.

Trinity College, Dublin.

THE following candidates passed the Final Medical Examination (Part I.), Michaelmas, 1907:—David J. Miller, Edward J. H. Garstin, Alex. K. Cosgrave (Passed on High Marks), William A. Nicholson, Richard J. Attridge, William H. Sutcliffe, Harold S. Sugars, Edwin B. Bate, James E. M'Causland, James D. Murphy, Richard D. FitzGerald, Howard S. Millar, Frederick R. Sayers. Intermediate Medical Examination (Part II.).—Henry H. James, Walter E. Adam, Victor W. T. M'Gusty, Hans Fleming, William H. Hart, Denis J. Stokes.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

The Habitual Vomiting of Nursing Infants.—Peiser (*Berlin Klin. Woch.*, July, 1907) recognises three forms of habitual vomiting in infants. The first occurs in healthy appearing babies, who receive too much food at one feeding, or are fed too often, or the milk is too rich in fat. These cases are easily controlled by regulating the amount and the number of the feedings, or by cutting down the fats. A second form occurs in children who, though apparently well nourished, are of nervous temperament, awake easily, cry much, and are easily irritated. Here the vomiting occurs from two to four hours after feeding, when normally the stomach should be empty. Often in this class of cases laryngismus stridulus or tetany occurs. In certain families, with marked neurasthenic tendency, all the children are subject to this form of habitual vomiting, which is extremely resistant to treatment, and finally disappears spontaneously. The author considers this form to be due to a pyloric spasm, more easily excited in such highly-strung children. The third form occurs in badly nourished, weak infants, and is more a regurgitation than an actual vomiting. In observations on such children with the X-ray, the stomach was dilated, and the period of gastric digestion prolonged. The vomiting in this latter class of cases takes place three or four hours after feeding. The cause is probably a weakness of the musculature of the stomach, and particularly of the cardiac orifice, which allows of a regurgitation of food. The treatment of this third form is general, and not until the general condition of the child is normal will the regurgitation disappear. D.

Nucleinate of Soda in Peritoneal Infections.—Chantemesse and Kahn (*Bull. de l'Acad. de Méd. Paris*, July, 1907) have found that nucleinate of soda, 1 to 100, injected hypodermically, at once arouses a rather lasting increased phagocytic action in peritoneal infections. In two cases they have even seen the classic symptoms of typhoid perforations ameliorated to such an extent as to render operation hopeful, by the two or three injections given from fifteen to eighteen hours after the first signs of the perforation. The patients refused operation, dying twelve days later of slow peritonitis, and the autopsy revealed a very marked defensive leucocytic and connective tissue process in the abdomen, the large perforations being almost thoroughly obliterated. They see a decided utility in the action of the drug in such conditions, and one not limited altogether to peritoneal inflammations, as they have seen it of value also in erysipelas and pneumonia. The reaction is moderately severe, which is to some extent a drawback. D.

The Gastric Secretion in Nephritis and Dechloridation.—Enriquez and Ambard (*Semaine Médicale Paris*, August, 1907) have found that deprivation of salt in diet seems to have a levelling effect on the gastric secretion. In both hyperchlorhydria and hypochlorhydria the absence of salt from the diet brought the gastric secretion to practically a uniform level, very close to normal. Their tests further demonstrated that every nephritis, even the latent form, has a marked influence on the gastric secretion. When there are merely traces of albumin or even simple arterial hypertension in the kidney, hyperchlorhydria is observed. It is probably, they state, the result of the excess of salt in the organism, salt being the general stimulant *par excellence* of the gastric secretion. Retention exaggerates the gastric secretion, while deprivation of salt reduces it. On the other hand, in nephritis with albuminuria, the retention of it seems to irritate the stomach mucosa just as it irritates the kidney lesion. In this case the stimulating action of the salt is overcome by its irritating, and therefore depressing action, with hyperchlorhydria as the result. But for the same reason that deprivation of salt has a beneficial action on the excessive secretion, it also has a beneficial action on the deficient secretion. Deprivation of salt allows the stomach mucosa to recover its tone even before the general salt balance throughout the organism is restored, and thus dechloridation is liable to be followed by a brief, transient hyperchlorhydria. The effect of salt starvation on perverted secretions opens, they state, a new field for the study of the pathology of the stomach, while at the same time it suggests a rational mode of treatment for many forms of gastric affections which at first glance seem to have no connection with each other. D.

Acute Yellow Atrophy of the Liver in consequence of Chloroform Anæsthesia.—(*Arch. f. Klin Chir.*, Berlin, 1907). Galeke's patient was a robust young woman, on whom a herniotomy, lasting half-an-hour, was performed, under 25 c.c. of chloroform. The anesthesia was unusually smooth; hernial sac contained only omentum. Jaundice and cholemia developed in less than 24 hours, and at the end of 92 the patient died in coma, after delirium and convulsions. The microscope revealed extreme destruction and fatty degeneration of the cells in the liver and in the convoluted tubules in the kidneys. The chloroform was evidently responsible for the trouble, as infection and thrombosis could be excluded. The same chloroform, used for other patients the same day, caused no by-effects in other cases. All the similar cases of yellow atrophy of the liver on record, following administration of chloroform, terminated fatally in from three to six days. The patients were generally young and robust. It is noticeable that the operations had always been abdominal, and that the patients were moderately or extremely fat. Other facts are cited which suggest that an unusually fat liver is less resistant to chloroform than one less so. D.

Examination of the Fæces for Occult Blood.—Goodman (*Amer. Journ. Med. Sciences*, Oct., 1907) discusses the value of the various tests for recognising the presence of blood in the fæces that is not evident to the naked eye. The test which Goodman has found most valuable is a modification of the benzidin test of O. and R. Adler. It is performed as follows: A concentrated solution of benzidin is made by using as much benzidin as will go on the end of a knife in about 2cc. of glacial acetic acid. A small piece of fæces about the size of a pea is suspended by stirring in a test tube, one-fifth full of water; the test tube is closed with cotton wool and the contents boiled. Ten to 12 drops of the benzidin solution are poured into a test tube, and from 2.5 to 3cc. of a 3 per cent. H_2O added. To this then are added from 1 to 3 drops of the boiled fæces, and in the presence of blood the colour becomes green, blue-green or blue, according to the amount of blood present. Even with very small amounts of blood the colour change is completed in about two minutes. If there is no blood present the colour is unchanged. Goodman has used this test extensively, and finds it very reliable under certain restrictions. If the test is negative one can be quite sure that no blood is present, but if it is positive the result should be confirmed by some other test. It is of great importance that all disturbing factors should be removed before the test is applied. Goodman advises that if the fæces show a positive reaction for blood, another stool should not be examined until the diet and medication have been regulated. K.

Early Diagnosis of Cancer of the Stomach.—Stone (*Amer. Journ of Med. Sciences*, Oct., 1907) analyses the various forms of evidence on which an early diagnosis of cancer of the stomach can be made. He dwells on the importance of remembering that cancer of the stomach can no longer be looked on as a rare disease in patients under 35 years of age. The earliest symptoms are those of simple dyspepsia coming on some hours after a meal and during the height of digestion, and he agrees with Boas that these symptoms are usually vague and indefinite in their onset. The ultimate diagnosis, of course, rests on the physical examination of the stomach and its contents. Free HCl. is absent in from 90 to 92 per cent. of the cases, and this, combined with the presence of the Oppler-Boas bacilli, is of the greatest importance in the diagnosis. The detection of what is called occult blood in the stools and stomach contents is also of very great importance. Such hæmorrhages are never found in healthy individuals. The blood is detected by the benzidin test, and it is said that it is present in practically every case of cancer of the stomach. In applying this test it is important that no meat or raw vegetables should be eaten for two or three days before the stomach contents and fæces are examined. Stone urges the adoption of Mayo's maxim that "a suspicion of cancer of the stomach, which cannot be disproved by known methods within a short time, should lead to exploration." K.

Bier's Hyperæmia.—MacLennan (*Practitioner*, Oct., 1907) describes this method of treating microbic invasions. In treating lesions of the limbs all that is necessary is the application of an elastic bandage round the limb on the proximal side. The degree of tightness of application is of considerable importance. One should remember that the object is to impede the return flow of the blood only, and that the pulse in the limb must not be affected. The skin of the part on the distal side of the limb should be of a uniform brilliant red colour, the limb should become warmer, and the patient should not experience any pain. The pain in the diseased part is at once relieved by the application of a bandage if the treatment is to do good and is being carried out properly. In acute cases this action is continued for 22 hours, and then there is an interval employed in reducing the œdema by elevating the part, and, if necessary, by massage. In parts of the body where an application of the bandage is not possible, the treatment may be carried out by reducing the atmospheric pressure on the part by suction. This method is particularly suitable to localised inflammations. In the treatment of abscesses only a small puncture is made, and when the bleeding has stopped, the suction is applied, and by this means the pus is withdrawn from the cavity. In such a case the suction may be continued for an hour, with intervals of three minutes every five. The usual dressing is then applied, and next day a similar procedure is repeated. If the puncture has closed, it should be picked open before the suction is reapplied. In the treatment of tubercular joints Bier recommends that the congestion be maintained only for an hour a day, as against the 22 hours recommended for acute infections. K.

Blood Changes Subsequent to Excision of Spleen.—Matthew and Miles report the result of a systematic examination of the blood of a patient whose spleen had been excised for traumatic rupture. The excised spleen was healthy, and consequently the case was a most favourable one for observations, and as observations were carried on over a period of two years and three months, both the immediate and remote blood changes were noted. They sum up their results as follows:—(1) After extirpation of the spleen, an enlargement of various groups of lymphatic glands occurs. The increase in size sets in early after the operation, is not of any great degree, is probably general, and is not permanent. (2) Corresponding to the lymphatic hyperplasia, there appears in the blood an absolute increase of lymphocytes. This increase persists in man for years after removal of the spleen. (3) A moderate eosinophilia appears soon after extirpation, and after persisting for some weeks again subsides. During the period of eosinophilia the blood plates are very numerous. (4) After recovery from the loss of blood, the red cells and hæmoglobin follow a normal course. (5) After excision of the spleen, individuals who recover suffer no inconvenience.
M.

Addison's Disease in Children.—Felbebaum and Fursthandler point out (*New York Med. Journal*, Aug. 10th, 1907) that Addison's disease is very rare in children. The number of reported cases is about equal in the two sexes, and the most usual recorded age is between 10 and 13 years. The typical form is characterised by its very prolonged course, accompanied by increasing weakness and gastric symptoms. In the rarer atypical forms the disease runs an acute course, and as the skin symptoms are often absent, the diagnosis is seldom made before the autopsy. Pigmentation, when present, is of a dusty bronze colour, most marked about the face, axillæ, knees, abdomen, and genitilia. The gastro-intestinal symptoms consist of loss of appetite and constipation, with occasionally diarrhœa. The pulse is small and feeble, and as a rule the temperature and urine are normal. The disease may last years, and may be characterised by occasional periods of intermission, death finally occurring with delirium and convulsions. The most common pathological change found is tuberculosis of the suprarenals, but cystic fibrous degeneration, and more rarely carcinomatous growths, have been recorded.
M.

The Value of Formamint in Septic Affections of the Oro-Pharynx.—M. de Santi has given an extensive trial to formamint in septic throat conditions, and now reports his opinion concerning its value in such cases (*Medical Magazine*, March, 1907). The drug is a combination of formic aldehyde and lactose, and when the latter becomes dissolved in the saliva, the formaldehyde is set free, and is able to exert a strong antiseptic action. De Santi has used it in the following conditions:—(1) Acute suppurative tonsillitis; (2) In the post-operative treatment of tonsillotomy and removal of adenoids; (3) Septic ulcerations of the pharynx; (4) In scarlet fever; (5) In acute septic infection of the pharynx and larynx; and reports very favourably of its value in all of them. He sums up its advantages as follows: (1) It is a proved antiseptic and bactericide, and is non-toxic in action; (2) It is far more efficient in its action than gargles or mouth washes; (3) Its pleasant taste makes it particularly suitable for children; and (4) Its portability is often a matter of considerable convenience. M.

The Excretion of Creatinin and Uric Acid in Some Diseases Involving the Muscles.—Spriggs writes an elaborate report of some investigations made into the excretion of creatinin and uric acid in various muscular diseases. He summarises his results as follows (*Quarterly Journal of Medicine*, Vol. I., No. 1, page 63):—(1) In two cases of primary muscular dystrophy the amount of creatinin in the urine was small, and the diminution was proportional to the muscular wasting; (2) In a case of myotonia congenita the excretion of creatinin was also low, in one of myasthenia gravis it was diminished in lesser degree, and in one of locomotor ataxia not at all; (3) In two cases of tetanus and one of spastic hemiplegia in a general paralytic there appeared to be only a slight increase; in a case of spastic paraplegia the excretion was normal; (4) In all these cases the excretion of uric acid deviated but little from the normal, being highest in the cases of tetanus and of spastic hemiplegia. From the above facts it is concluded: (*a*) that by far the greater part of the endogenous creatinin of the urine is derived from muscular tissue, but that it is a product of its internal structural metabolism, and not of its contraction; (*b*) the source of by far the greater part of the endogenous uric acid in the urine is to be looked for in the non-muscular tissues. M.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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PAUL.—The question of priority in the discovery of the infection of Malta fever is definitely settled by Colonel David Bruce, C.B., R.A.M.C., who states that the actual observation which led up to this discovery was made by Dr. T. Zammit, the Maltese member of the commission which was despatched by the Royal Society. Colonel Bruce's own words are:—"I went out to Malta as Chairman of the Commission in May, 1905, and discussed results of the work of those members of the Commission who remained in the island during the previous winter. I saw Dr. Zammit's notes as to two experiments on the effect of feeding goats on material containing *Micrococcus Melitensis*. I urged Dr. Zammit to continue his investigations, and he accordingly bought a small herd of goats. Before proceeding to repeat the feeding experiments on these new goats he examined their blood, as a matter of routine, and, much to his surprise, found that five out of six gave a Malta fever reaction. He then took specimens of the blood to Major Horrocks, another member of the Commission, and asked him to confirm his observations. This Horrocks did; and at once Dr. Zammit and he proceeded to examine, the former the blood and the latter the milk of the goats, for the *Micrococcus Melitensis*, with the result, as is well known, that this micro-organism is found in the blood, and excreted in the milk, to the extent of 10 per cent. of the goats of Malta."

AN UNLUCKY NAME.

DR. C. B. GRAVESTONE, a Chicago physician, who informed his creditors that he had been ruined by his name, had simply missed his vocation. He should have been a monumental mason. —*Star*.

Dr. H. S. T.—The "method of M. Boeri" is what is called Respiratory Auto-Massage of the Abdomen, and is prescribed in habitual constipation. The patient lies on his back (for preference) and makes deep inspirations and expirations, hollowing out the abdomen as much as possible during the latter. It is claimed, and reasonably so, that the intestinal contents are thus naturally acted upon.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 6TH.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. M. Collier: Clinique. (Surgical.) 5.15 p.m.: Lecture: Dr. C. R. Box: Bacterial Invasion of the Urinary Tract in Childhood.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

THURSDAY, NOVEMBER 7TH.

RONTGEN SOCIETY (20 Hanover Square, W.).—8.15 p.m.: Presidential Address:—Mr. W. Duddell: The Production of High Frequency Oscillations (with demonstrations).

NORTH-EAST LONDON CLINICAL SOCIETY (Prince of Wales's Hospital, Tottenham, N.).—4.15 p.m.: Clinical Cases.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. T. G. Stewart: The Diagnosis of Cerebellar Tumours.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel).

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: The Solution of the Confusion between Pityriasis Rubra Pilaris and Lichen, and the Treatment of each.

HOSPITAL FOR SICK CHILDREN (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. Waugh: Appendicitis.

FRIDAY, NOVEMBER 8TH.

ROYAL SOCIETY OF MEDICINE (CLINICAL SECTION) (20 Hanover Square, W.).—8.30 p.m.: Exhibition of Cases. Short Paper:—Dr. J. Fawcett: Pneumothorax treated by Aspiration under X-Rays. The Patients will be in attendance at 8 p.m.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. H. L. Eason: Clinique. (Eye.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Appointments.

BURKE, GERALD T., M.B., B.S.Lond., Senior House Physician at the Prince of Wales' General Hospital, Tottenham, N.

HARRIS, HENRY E., L.D.S., Dental Surgeon to the Royal National Orthopædic Hospital of London.

JAGO, W. J., M.R.C.S., L.R.C.P., Assistant House Surgeon to the Taunton and Somerset Hospital.

LEWTHWAITE, ALFRED, M.B.Lond., L.R.C.P.Lond., M.R.C.S., Resident Medical Officer at the Winsley Sanatorium.

REES, EDWARD DAVIES, L.R.C.P.Lond., M.R.C.S., L.S.A., Medical Officer of Health by the Newtown and Llanidloes Rural District (Montgomeryshire) Council.

STIDSTON, C. A., M.B., B.S.Lond., M.R.C.S.Eng., L.R.C.P.Lond., Resident Medical Officer and Secretary to the General Infirmary, Hertford, Herts.

Vacancies.

King Edward VII. Sanatorium, Midhurst, Sussex.—Pathologist. Salary, £250 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19 Devonshire Street, Portland Place, W.

West Riding Asylum, Wakefield.—Assistant Medical Officer. Salary, £150 per annum, with apartments, board, washing, and attendance. Applications to the Medical Director.

Leicestershire and Rutland Asylum.—Junior Medical Officer. Salary, £130 per annum, with board, lodging, and washing. Applications to W. J. Freer, Esq., 10 New Street, Leicester.

The North Riding Lunatic Asylum, Clifton, York.—Junior Assistant Medical Officer. Salary, £150 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Warrington Infirmary and Dispensary.—Senior House Surgeon. Salary, £120 per annum, with furnished residence and board. Applications to J. H. J. Hampson, Secretary.

Down District Lunatic Asylum, Downpatrick.—Junior Assistant Medical Officer. Salary, £130 per annum, with furnished apartments, board, washing, fuel, light, and attendance. Applications to the Resident Medical Superintendent. (See Advt.).

Castlebar District Lunatic Asylum.—Assistant Medical Officer. Salary, £100 per annum, together with annual allowances, including £50 in cash. Applications to Joseph T. Kelly, Clerk of Asylum. (See Advt.)

Births.

CARLYON.—On Nov. 1st, at Yeoville, Johannesburg, the wife of F. Harold Carlyon, M.D., C.M., of a daughter.

HUNTER.—On Oct. 29th, at Lynher House, High Street, Clapham, London, the wife of S. R. Hunter, M.D., M.Ch., of a son.

MICHELL.—On Oct. 26th, at 3, Trinity Street, Cambridge, the wife of Robert Williams Michell, M.D., F.R.C.S., of a son.

MISKIN.—On Oct. 31st, at Lonsdale House, Court Road. Eltham. the wife of Ernest Miskin, M.B.Lond., of a daughter, who survived his birth five hours.

Marriages.

FAIRLIE-CLARKE—LYELL.—On Oct. 31st, at St. Stephen's, Gloucester Road, London, Allan Johnston Fairlie Clarke, M.C., F.R.C.S., of Horsham, Sussex, youngest son of the late W. Fairlie-Clarke, M.D., F.R.C.S., to Violet, elder daughter of Captain F. H. Lyell, of Oakwood Hill, Surrey.

Deaths.

JOLL.—On Oct. 28th, at 1, Elm Grove Road, Ealing Common, Boyd Burnett Joll, M.B., M.R.C.S., formerly of Woolton, Liverpool, and Bedford Square, London.

PAUL.—On Nov. 1st, from a gun accident, Vining Paul, M.R.C.S., M.R.C.P., only son of the late J. M. Paul, of Upper Assam, India, and of Mrs. Paul, of Dovercourt, Essex.

SCOTT.—On Nov. 3rd, William John Scott, L.R.C.S., L.R.C.P.I., of Hurstpierpoint, Sussex, aged 46, second son of Richard Scott, solicitor, of Dublin.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

Juvenile Smoking.

THE anti-juvenile smokers are already on the alert for next session, for they succeeded last week in bearding the Under-Secretary at the Home Office and drawing from him official benedictions and platitudes. The fact of the matter is that the Home Secretary has his hands so full of pressing reforms and departmental Bills that he is not likely to give up much time to a petty matter of this kind. While of course no one approves of juvenile smokers, to hear the language on the subject used by some good folk, it might be imagined that the fate of the Empire depended on news- and errand-boys abjuring the "fag." It might not be objectionable in itself to make the retailing of tobacco to youths under sixteen an offence, especially as the cigarettes put up to catch youngsters are usually of the worst possible quality, but it would be nothing less than an outrage on common sense to make it a police court offence for lads to smoke in the streets. The amount of harm they would get from being treated by the law as prisoners, and from the associations of the police-court and the dock, would be infinitely greater than any physical deterioration they would be likely to suffer from puffing a little tobacco. So long as men smoke boys will imitate them, and we could only wish it was the worst habit they picked up from their elders.

The Triumph of the Midwife.

A CURIOUS gathering took place at Rotherham last week, namely, a combined tea-fight for midwives and prize-show for infants. The Mayor was in the chair, and Dr. Robinson, the Medical Officer of Health, addressed the company. In his speech, Dr. Robinson spoke of the waste of infant life that was going on in the country, and of the methods by which it might be averted. Foremost among these he placed the influence of educated midwives and the early notification of births. Figures were given showing that whereas the infant death-rate for England and Wales was 133 per 1,000, that of Rotherham was, on the average of the last ten years, 160 per 1,000. Since the introduction of early notification to Rotherham there had been 923 births, with 94 deaths, among infants whose mothers had been attended by midwives, against 910 births, with 177 deaths, among those not so attended. "He regarded this difference in favour of Rotherham midwives as extraordinary." So, indeed, do we, for the obvious inference is that infants do about twice as well when the mothers are attended by midwives as when they are attended by medical men. Prizes of sovereigns and shawls were then distributed to the midwives who had been most successful, and the mothers of the lustiest infants were made happy by similar presentations. While we have the greatest sympathy with all efforts made to check "the massacre of the innocents," we cannot think that figures that show so much are not capable of some other interpretation.

Tomato Putrifiée.

PEOPLE with a partiality for tomato purée may be interested to hear the opinion of the Medical Officer for the Port of Manchester on that delicacy. Two hundred and fifty-four tins of this stuff were recently seized by him, and the contents were found to be in a very revolting condition. We learn from the medical officer some of the tricks of trade with regard to tomato purée and other kindred goods. It is well known that when such articles of food putrify they give off gas which bulges out the side of the receptacle. Such tins are said to be "blown," and, being easily detected by their external appearance, are pounced on by the inspector. The owners are now as wily as their natural foe, and when tins are blown they puncture them, let out the gas, and solder up the hole, the chances being that the putrid stuff will be eaten before enough gas has been formed to bulge the tin again. Another trade dodge is what is known as the "sneaking" method, the removal of the lid of the tin to let out the gas, and the resoldering of it. Revelations of this kind are simply nauseating, and we feel at a loss for suitable comment. The only fit punishment we can think of is to sit the perpetrators of these tricks in a prison cell with no other food to eat but their own dainties, and the only effective one under modern humane conditions to advertise the names of the makers and their stuffs all over the kingdom, so that all may know what not to buy. Perhaps it was from dealings of this kind that tomatoes gained their legendary property of causing cancer.

London University Election.

THE election of a new member of the London University Senate by the Faculty of Medicine re-opens the controversies which were supposed to be settled by the recent election of Dr. Caley and Mr. Leonard Hill; it may be hoped that the electors will clearly realise the alternatives before them. Dr. Norman Moore and Mr. Wallis are asking for votes to help them oppose the scheme for a central institute for preliminary medical study, while Professor Starling appeals for votes in its favour. After all the crises London medical education has been through, no crisis, perhaps is more profound than that in which the small schools find themselves at present, and after all the bitter lessons of the past, it might be hoped that the present University graduates would be prepared to sink their own particular wishes in a desire to combine for the common good of the London student. At present this unfortunate individual is placed in the position of having the largest variety of clinical material in the world, and teachers whose names are often household words, and yet he is denied the routine advantage enjoyed for centuries by every Scotch lad who studies at a metropolitan or provincial university, namely, that of acquiring a university degree as the natural crown of his studies. All the reconstruction and re-fashionings of the London University will fail until the graduates who govern the University are prepared to make it a University *for* London. This policy they seem still opposed to, and people wonder why London is waning in popularity as a medical centre. As a matter of fact, for some of the famous, but smaller, schools the position is only just short of an *impasse.*

Medical Men and Sanitary Officials.

LAST week we commented on the state of sanitary administration at Manchester, and the insolent way in which the sanitary inspectors invaded the privacy of the homes of the poor and hectored them. We have since had the opportunity of reading an article in the *Manchester Evening Chronicle*, contributed by a medical man, in which the subject of medical notification is dealt with. The writer, in common with the members of the Manchester Medical Guild, protests strongly against the conduct of the inspectors, and he proceeds to discuss the general questions of notification as regards medical practitioners. He shows how distasteful to medical men it is for them to be turned into spies and informants as regards their patients, and he shows how the feelings of many medical men against notification of the ordinary infectious diseases having been overcome, the State has proceeded to extend the principle to voluntary notification of consumption, and now to compulsory notification of births. This method of getting from practitioners information obtained in the confidential relation of doctor and patient can only be justified on the ground of the greatest necessity, and it cannot but tend to erect certain barriers which should not exist between medical men and the patients, especially when the latter are poor. When, as in the case in Manchester, notification brings in its train a sanitary official, breathing out pains and penalties, it certainly is time to protest. The poor have their rights even when they are ill, and doctors, though wishing to co-operate in every way with health administration, do not wish to be made catspaws of a high-handed beaurocracy.

The "Kilkenny Cat" Position.

IN our last issue we published a letter from Miss Beatrice Kidd, in which, with a certain lack of gratitude, she said that the Hon. Stephen Coleridge, who has borne the burden of the "cause" in the heat of the day, "can hardly be called an anti-vivisectionist at all." We admit to having frequently been at a loss to define the exact views of that gentleman, but are we really to admit Saul to a seat among the prophets? That prospect does not seem likely to materialise in the immediate future, but Miss Kidd, having thus thrown Mr. Coleridge to the vivisecting wolves, proceeds to announce that, "on the side of the anti-vivisectionists we have a happy family party remaining." The happiness that animates this family party must, we fancy, be more the joy of combat than the domestic felicity of the fireside. For, apart from Mr. Coleridge's National Anti-vivisection Society, we have heard of the London Anti-vivisection Society, the British Union for the Abolition of Vivisection, the Parliamentary Union for the Suppression (or Abolition) of Vivisection, and the World's Union (or League) for the same, to say nothing of the Canine Defence League. We dare not trust our memory further, but we believe there are yet others. The worst of the "happy family" is that each member of it seems to want something different from the others, and if anyone approves of anything the rest show their zeal by promptly expressing discontent with their brother's conclusion. So far as we understand Miss Kidd's wishes, as expressed in her letter to us, they lie in the direction of abolishing medical inspection of experiments. Supposing the Commissioners recommended that this change should be brought about, and experimenters were able to work without the tutelage of the Home Office, how could one be sure that all the other societies and unions and Leagues would be satisfied too?

LEADING ARTICLES.

MEDICAL OFFICER'S REPORT TO THE LOCAL GOVERNMENT BOARD.

THE report of the Medical Officer to the Local Government Board is always a volume of the highest importance to the nation, and though nothing of a sensational nature is recorded in it this year, the standard of general interest is well maintained. As indicating the growing feeling in favour of sanitary matters all over the civilised world may be taken the fact that each year the international and imperial service rendered by the medical departments grows in size and importance. In 1905, for instance, the Government, on the invitation of France, appointed two delegates, Dr. Theodore Williams and Dr. Timbrell Bulstrode, to attend the International Congress on Tuberculosis, and though their report was technically presented to Parliament, probably nobody in Parliament looked at it; but on the other hand the medical department of the Local Government Board have abstracted from it all that is likely to be of help in the solution of tuberculosis problems in this country. Specially interesting are the efforts being made in France to catch individuals, especially children, in the "pre-tuberculous" stage, and to provide institutions in favourable spots and under favourable conditions for their reception. Again, the French "anti-tuberculous dispensaries" provide an experiment in medico-social work that should be carefully watched with a view to its imitation over here if necessary. These dispensaries act as a buffer between the sanatorium and other charitable agencies for the sick poor, and by meeting the wants of the latter in good time—even to the socialistic extent of supplying food and clothing when necessary—their supporters seek to ward off the conditions that predispose to tuberculous disease. From the less utilitarian standpoint, much interest also attaches to the views on "latent" tuberculosis expressed at the Congress, the idea being expressed that tubercle bacilli are frequently received into the tissues of children from one source of infection or another, and these lie dormant till some concatenation of circumstances in the altered condition of child-life render the subject vulnerable to their attack. Useful "imperial" service was rendered to the country by Dr. Theodore Thomson, who was sent to report on the advisability of establishing a sanitary station on the Persian Gulf in accordance with the proposals of the International Sanitary Convention of Paris in 1903. Dr. Thomson from his practical knowledge was able to point out that not only was there small danger of cholera and plague proceeding from the Persian Gulf, but that the sanitary station, if established, would not do much towards coping with it if it did arise. Moreover, the Gulf is so unhealthy and the expense of the station would be so large, that he advised that such an establishment would certainly be a mistake, and that an organisation should be prepared at Basra and Mohammerah to deal with the inland incursions of epidemic diseases.

In domestic affairs the department have been busy too. Freed from the necessity of looking after outbreaks of small-pox, the staff was employed in a more generous manner than is often possible in inspections and examinations. A rather disappointing account is given by Dr. Parsons of the £150 cottages on the Letchworth estate. From what we heard and read of these cottages, we were inclined to believe that there was no reason why a thoroughly satisfactory cottage should not be erected for that sum; but Dr. Parsons was not satisfied with a good many features they presented. We are inclined, however, to think that he was in a rather pessimistic frame of mind when he wrote his report, for one of the points he deplores about the houses is that the staircases of some are so winding that it would be "practically impossible to remove a full-sized coffin from the first floor by the staircase!" It might be hoped that in model cottages on a model estate, the necessity for such an event would be comparatively infrequent; at any rate if the melancholy need were to occur, special arrangements might be made, according as the wit or ingenuity of the undertaker suggested. An important report is made by Dr. Bruce Low on the vaccine establishments in Germany. The principle adopted in that country is to decentralise the manufacture of lymph; but as this entails great multiplication of machinery and buildings, and certainly the risk of lack of uniformity in results, we do not see that such a system is called for in this country. As a lesson in German systematisation and exactitude, however, the report is instructive.

One new and decided step forward has been taken by the Board, namely, that of setting up a special sub-department under Mr. Power's general guidance for the supervision of the administration of the Food and Drugs Act, Dr. Buchanan being appointed its provisional chief with the title of Inspector of Foods. An extensive enquiry has already been made by him into the danger of meat from tuberculous pigs in London; but unfortunately its length precludes its being reproduced in the medical officer's report. The usual inspections took place during the year under notice, some, especially the inspections of Basingstoke, Lincoln, and Fulbourne Asylum being of more than ordinary significance and importance. In appendix B we find reports from the researchers employed by the Board, Dr. Klein having three papers, Dr. Sydney Martin, Dr. John Wade, and Dr. Gordon one paper each, and Drs. Andrewes and Gordon a joint paper. It is not possible here to give any adequate idea of the scope of these contributions, but the most pretentious, undoubtedly, is the first one of Dr. Klein's, namely "On a New Plague Prophylactic." Let us hope it may prove so.

It is a matter for reflection that while the work of the medical departments of the Local Government Board is some of the most important and responsible in the country, and while, moreover, it is exceedingly well done, the amount of interest taken in it by the general public is practically nil. Perhaps after their vaccination experience of the lime-light of publicity, the department is not unduly cast-down after all.

A BLOW TO QUACKERY.

The issue of the recent article for libel brought against Mr. Labouchere, of *Truth*, registered a notable advance in the campaign against quackery. A verdict has been given and judgment returned in favour of the defendant. This result shows that it is still possible in the United Kingdom with impunity to call gross quackery by its proper name, and to expose the malpractices of charlatans who prey upon the public by professing to cure their maladies. The medical profession must admit their indebtedness to *Truth* in this matter, although at the same time we must repeat our contention that the journal in question admits to its columns quack advertisements of an obviously objectionable character. The fact that *Truth* accepts money for the insertion of advertisements of that class clearly weakens its position as a *censor morum*. Apart from this criticism, the editor of that incisive journal may be congratulated on the ending of the long-drawn-out and costly legal proceedings in the case of *Dakhyl v. Truth*. The plaintiff, who complained of being libelled, is a Doctor of Medicine of Paris. He came to England and assumed the direction of the notorious Drouet Institute for the treatment of deafness. The methods of that organisation have long been the subject of unsparing attack in the columns of *Truth*. They afford a scathing indictment of the laxity of British law in the protection of the public against the machinations of gross and unblushing quackery. The history of the Drouet Institute, properly unfolded, would be sufficient in itself to warrant the demand for new and stringent Medical Acts. Of what use is it to secure a proper education of qualified medical men and to label them so that they may be recognised by the community, if on the other hand any ignorant and unqualified person is permitted to advertise his claims as a curer of all and every ill that flesh is heir to by means of potions, charms, appliances, manipulations, and a host of special methods of every conceivable kind? The evil is immeasurably great, and it must one day be rooted out when society attains a higher general level of intelligence. Meanwhile, the nation pays the toll of its folly in the ruined health and the lives of the victims of patent medicine vendors and charlatans. As a practical outcome of the case under consideration, there has emerged a sort of judicial recognition of the definition of the word "quack," as one who professes to cure many diseases with one remedy. Mr. Justice Darling added the pronouncement that quackery might be practised by the holders of the highest medical qualifications. We imagine that the truism laid down by the learned judge has an application to professions other than that of medicine. At the same time he may be thanked by all honest citizens for having bestowed a good, hearty buffet upon that evil thing, quackery.

CURRENT TOPICS.

The Pollution of Rivers.

IN many ways the legislation of the United Kingdom, even in matters that are apparently of an urgent nature, is curiously slow and deliberate in its inception. Take the question of the pollution of rivers, about which there can hardly be at the present time any serious difference of opinion. The subject has been under the consideration of the Royal Commission on Sewage Disposal for the last nine years. It has been once again brought into prominence by a deputation from the British Science Guild which was last week received by Mr. John Burns at the Local Government Board. Sir William Ramsay pointed out that some permanent arrangements should be made to carry on certain aspects of the work of the Royal Commission on Sewage Disposal. It was true that a few local river boards existed, and were doing good work, but many more were wanted. A central body with authority to deal not only with the question of river pollution but with the whole question of water supply, was absolutely essential in order to map out catchment areas for districts and to keep them free from pollution. Unless something of the kind were done, twenty-five years hence it would be too late, and things would be in an extremely bad condition. Unless such a central board were created litigation could not be avoided in all these matters, and he instanced one case where £12,000 had been spent needlessly under present conditions. The cost of the present Royal Commission was roughly about £4,000 a year; but this expense would cease if a central board were created. The Commission, indeed, wanted to resign, but could not do so on account of the necessity of continuing the work. He did not think that the cost of the working of a central body, equipped properly for both chemical and biological work, would be greater than £6,000 or £7,000 a year. Mr. Burns received the deputation in a sympathetic speech, and expressed an opinion that the Local Government Board should be the central and joint authority in the matter of river pollution. The Bill he hoped to bring forward in the spring of next year would have to be warmly endorsed by public opinion in order to become a success.

A Model Sanitary Committee.

GRATITUDE for long and faithful medical public service is not often so conspicuously shown as by the townsfolk of Swansea in the case of their retiring borough and port Medical Officer of Health. After forty-two years in the service of the Corporation, Dr. Ebenezer Davies felt compelled to send in his resignation owing to his ever-increasing duties. Thereupon, an influential deputation from the Swansea Medical Association waited upon the Sanitary Committee of the town, and urged that Dr. Davies should be appointed Consulting Medical Officer, and that his successor be a well-trained bacteriologist in addition to the other necessary qualifications. The committee decided to advise the appointment of Dr. Davies as Consulting Medical Officer of Health at £100 per annum, and to appoint a successor at a salary of £700 or £800 a year. This graceful recognition must be gratifying to Dr. Davies, accompanied as it was with many expressions of esteem and respect. In introducing the deputation, Dr. Griffiths spoke of his work as always of an unostentatious character, and said that in the profession they looked upon him as a model of courtesy, consistency, conscientousness, and, he might say, honour. The relations between the Swansea Council and the Medical Officer of Health might well be taken as an example by many local authorities in other parts of the kingdom.

Plague in Glasgow.

A LOCAL outbreak of bubonic plague is announced in the Glasgow newspapers in a small district on the South Side. The nature of the disease has been confirmed by a medical officer specially despatched from the Local Government Board, Edinburgh. Patients have been promptly removed to the Belvedere Hospital, and "contacts" subjected to a fortnight's quarantine in the reception house. The invasion of a large town by plague is serious under any circumstances, but happily nowadays there is no need of a panic in our own comparatively well-ordered centres of population. Past experience, moreover, in this very locality is reassuring, for in 1900 plague appeared there, but was restricted to 36 cases, with 16 deaths. The following year it recurred in milder form. Its re-appearance in the same spot in 1907 renders it possible that the infection has persisted, and that it would have been wise to demolish the building where the disease formerly obtain a foothold.

Strait Jackets in Poor-Law Infirmaries.

FROM a medical point of view the use of the strait jacket, under any circumstances, is questionable, but most of all is it to be deprecated when left in the hands of laymen to administer. The Local Government Board appear to think the application of that antiquated appliance demands supervision, for they have intimated to the Hampstead Board of Guardians that an inquiry will be held with reference to the recent inquest on the body of an inmate of the workhouse. The peculiar circumstances of the case were that the man in question died in the observation ward of that institution after having been there seventeen hours, seven of which were spent in a strait jacket. From the newspaper report it is uncertain whether deceased was seen at all by a medical man, but it clearly intimates that he was placed in the jacket in the absence of medical orders. There is apparently no padded room in the workhouse, a fact that met with the Vice-Chairman's approval, if we may judge from the remark that such rooms were antiquated and undesirable. Of all things in the world we should have thought that that mild condemnation would have applied with a hundredfold force to the strait jacket. The whole question of, in our opinion, the Poor Law accommodation for refractory and delirious patients generally requires searching inquiry and stringent remedy in the interests of common humanity.

Birthday Honours.

ALL medical men will have found peculiar pleasure in seeing the name of Professor Clifford Allbutt in the Birthday Honours list. The honourable style of K.C.B. will sit on no worthier member of the profession; the only criticism we feel inclined to offer is that it has been long overdue. Dr. Allchin, another well-known physician and medical systematiser, has been made a knight, and Dr. Beatson, C.B., of Glasgow, long a devoted volunteer, has been promoted to the knighthood of his order. Both distinctions are well earned. Although not strictly medical, the knighthood of Mr. A. C. Scovell, who has been so long associated with the profession and with health administration in London, calls for special mention. It may be true that the world knows little of its greatest men ; it certainly is true that London is totally ignorant of the enormous debt it owes to Sir Augustin Scovell for his steady and fearless administration during the late small-pox outbreak. Two names are of special interest to Irishmen. Knighthoods have been conferred upon Mr. Robert Matheson, LL.D., who fills the important post of Registrar-General, and Dr. W. J. Thompson. Dr. Thompson, who is senior physician on the staff of Jervis Street Hospital, is one of the physicians to the Lord Lieutenant. He has been largely concerned in the working of the recent Tuberculosis Exhibition in Dublin. Mr. Robert Matheson is well known as a very able statistician. He, also, was deeply interested in the working of the anti-tuberculosis movement in Ireland, and contributed to the exhibition a large series of statistical tables relating to the same subject.

The Closing of the Tuberculosis Exhibition.

The closing of the Tuberculosis Exhibition in Dublin on Friday last was marked by lectures delivered in the theatre of the Royal Dublin Society by Sir Shirley Murphy and Dr. A. K. Chalmers on "The Control of Milk and Food Supplies and other Conditions affecting Tuberculosis," under the presidency of His Excellency the Lord Lieutenant. The subject of the lecture was well chosen, for up to the present Irish sanitary authorities have practically done nothing towards controlling the milk and food supplies with a view of preventing tuberculosis. It is, of course, too soon to judge of the effect of the exhibition as a whole. It is, however, safe to say that a degree of public interest in the question has been roused such as never would have existed before. It remains to be seen whether the public will insist, through the sanitary authorities, on making their opinions effective. We confess we have not much faith in the professions of the Local Government Board or of the various sanitary authorities. The former boasts of its energy and activity in pressing reforms on the local bodies, but this energy and activity began only a year or two ago, and little was heard of it until Lady Aberdeen brought the question to the front. The value placed by the Board on sanitary work may be judged by noting that the usual salary of a medical officer of health as sanctioned by them is £15 to £20 a year, and in some cases £5 a year. The local authorities, too, will always be obstructive until there is a strong public opinion to drive them on. If the exhibition has done any good, it is in the formation of this opinion.

Infantile Mortality in Durham.

The Archdeacon of Durham has made his triennial visitation at Durham notable by calling the attention of the clergy to the overcrowded population and the terrible infantile death-rate in the county. Speaking of the importance of the question of housing in Durham, he found that, while the population of Durham and Essex were practically the same, in Durham the percentage of overcrowding was 28.4 per cent., while in Essex it was 2.7 per cent. The deaths in Durham were 21,962, and in Essex 14,913. The rate of infant mortality in Durham was 156 per thousand births, and in Essex 115 per thousand, or three deaths in Durham to every two in Essex. They were better now in respect of overcrowding than they were twenty-five years ago, but they must be far better than they were that day before the clergy and laity could come to the conclusion that they had done their duty. Dr. Eustace Hill, Medical Officer of Health for the Durham County Council, pointed out that their county had the highest infantile mortality in England and Wales, with the exception of Glamorgan. One-third of the total number of deaths were infants under one year old, two-fifths of infants under two years, and nearly one-half under five years of age. Half of the total number of infants' deaths were preventable, and the total number of avoidable infant deaths were 100,000 yearly. In this matter the Archdeacon has set a worthy example to his fellow Churchmen, who will find in social reforms a field of altruistic labour worthy of the highest ideals and traditions of Christianity.

PERSONAL.

The King has bestowed another mark of his favour upon Sir Frederick Treves in granting him as a residence Thatched House Lodge, Richmond Park, a charming house standing in three or four acres of beautiful grounds.

The County Council of Bedford have appointed Dr. G. F. McCleary, Medical Officer of Health for Hampstead, as Medical Officer for Bedfordshire.

Professor Clifford Allbutt has been appointed a K.C.B. (Civil Division).

Dr. W. H. Allchin and Dr. W. T. Thompson have been made Knights Bachelor.

Lieut.-Colonel and Hon. Colonel G. T. Beatson, C.B., R.A.M.C. (Volunteers), of Glasgow, has been promoted to be K.C.B.

Dr. R. M. Coulter, Deputy Postmaster-General of Canada, has been appointed C.M.G.

Dr. Preston King has been elected to the Town Council at Bath; Dr. H. A. Latimer at Newport; and Mr. Paul Swain at Plymouth.

There is a vacancy for a medical member on the Senate of the University of London, caused by the resignation of Dr. Lauriston E. Shaw.

Dr. James Pearson, J.P., has been elected Mayor of Bootle for the present year.

Mr. W. H. Power, C.B., F.R.S., medical officer to the Local Government Board, has been awarded the Buchanan medal of the Royal Society.

Dr. Ronnaux, surgeon of the St. Julian Hospital at Cambrai, has contracted tetanus from an operation, and though his arm has been amputated his life is despaired of.

Dr. Louis C. Parkes, Medical Officer of Health for Chelsea, will introduce a discussion at the Royal Sanitary Institute to-morrow (Thursday) night on the "Smoke Problem Abatement Society."

The Public Health Committee of the Corporation of Dublin has presented a beautifully illuminated address to Sir Charles Cameron, C.B., Medical Officer of Health for Dublin City, in which the Committee congratulates him on the success of his efforts to improve the state of public health in Dublin.

A CLINICAL LECTURE
ON
DEFORMITIES OF THE FOOT ASSOCIATED WITH ABDUCTION.

By EDRED M. CORNER, B.Sc.Lond., M.C.Cantab, F.R.C.S.,

Surgeon in Charge of Out-Patients, St. Thomas's Hospital; Senior Assistant-Surgeon, Hospital for Sick Children.

GENTLEMEN,—To-day I want to talk about the reverse of what we were speaking about on Monday. I then showed you a number of slides illustrative of the deformities associated with the adducted position, which the foot assumes during activity. This afternoon I wish to show you a number of slides setting out the positions and deformities of the abducted foot, which position of abduction the foot assumes during rest. In this slide the arch of the foot is not much marked, although it is not entirely obliterated. And it is very useful in practice if you can remember that the foot can become abducted, and therefore present all the symptoms which you naturally associate with flat foot, and yet have a slight arch. The next slide shows the position of the bones of the foot in abduction or rest. The toes are turned outwards opposite the mid-tarsal joint. In contrast with that, I show you a slide of a foot in adduction or activity. In activity there is a raised heel and increased arch, the person standing on the toes. In the movement of adduction the toes are turned inwards and the movement has taken place about the mid-tarsal joint.

I now want to show you how this abducted position of the foot can be recognised in early life. Inactive, young, or weakly people turn their toes out; as people grow older their tendency is to assume the abducted position. This is caricatured in the shuffling gait of the aged. People who turn their toes out and have abducted feet do not lift their feet well from the ground, so that their gait is never as clean and neat as that of people having adducted feet. In people who maintain their feet naturally in the abducted position one finds long narrow feet, with smooth uppers of their boots. In the abducted foot the heel of the boot is always worn on the outer side. I remember one case where that point was brought prettily into the Law Courts. A man had sustained a Potts' fracture of his leg, and the result of the reduction of the deformity was to leave his foot in the flat or abducted position, a position which I fear is fairly common after Potts' fracture of any severity. The employer's insurance company, which was dealing with this man, refused compensation, and the case came to the Courts. A number of surgeons from the West End went to give evidence. The first surgeon-witness, an important and well-known man, had this pointed out to him; the patient's boot was produced to him. He explained very carefully to the judge and jury that the man now, as the result of the accident, was walking on the inside of his foot. The counsel on the other side produced the boot and asked this very important surgeon why it was, if the man walked on the inner side of his foot, he wore away the outer side of the heel!

The next slide shows the sole of an abducted foot; and you will notice a callosity occurs beneath the third toe. Sometimes instead of one callosity you find there are two. The callosity in the active foot is partly under the ball of the big toe. Abduction is the position of the slow, the heavy, the inert. It is associated with a number of deformities, which we can classify as (*a*) those taking place at the ankle joint, like talipes calcaneus; (*b*) those taking place at the mid-tarsal joint; and (*c*) those taking place at the metatarso-phalangeal joint. We have not time, nor would it be profitable, to go into all these deformities to any extent. We will speak of only a few.

First, there are deformities of the ankle joint. There may be a combination of *talipes calcaneus, valgus, and flat foot.* These factors are always present, and are quite inseparable in the acquired deformity. The acquisition of this deformity is largely dependent on the integrity of one muscle, namely, the tibialis posticus. That is a muscle in the calf of the leg whose function is the raising of the arch of the foot. Whenever the foot is active, as in springing and jumping, the heel is raised from the ground and the arch of the foot is increased, so that nobody can have an active foot unless the tibialis posticus is well developed. The peronei muscles are its great antagonists, and if those muscles have the mechanical advantage, the foot will flatten, and will enter into a position which you might call talipes equino-valgus, but which I prefer to call *pes abductus.*

Everybody is conversant with the ordinary condition known as flat foot, but I would impress upon you that people may come complaining of all the symptoms of flat foot, yet may not have a flat foot. *It is not flatness of the foot which leads to the complaint, but the abducted position of the foot.* There is a point here in regard to the treatment. The time-honoured treatment of cases of flat foot has been to teach them exercises; but if you have had the opportunity of watching a person who has been having his flat foot treated by exercises, you will have found that the exercises have certainly made him better, but they have not given an arch to the instep; the foot remains flat. The teaching of exercises has only recently come from Sweden into the hands of the more intelligent instructors. In connection with these exercises I would remind you that we are really considering only two muscles: the tibialis posticus and the peronei group. The first of these raises the arch of the foot, so that it is absolutely necessary to every person whose foot is to assume the position of activity. The peronei flatten the arch. The function of the peronei in ordinary people is to evert the foot. But if the foot is already flat it is already turned out, so the peronei cease to be everters of the foot and become flexors, like the other calf muscles. So if people whose feet are flat and therefore already abducted are taught tip-toe exercises in the ordinary way, those exercises will strengthen the tibialis posticus, and at the same time strengthen the antagonising peronei. But the exercise, while strengthening the muscle which raises the arch, also strengthens the muscle which flattens is, so the arch remains flat, although the patient is better. In this connection I would mention another condition which is associated with the abducted position of the foot, namely, ingrowing ankle. Unfortunately, these people are often put into strong boots with stiff uppers. That is a great mistake, comparable to putting a stiff jacket on to a case of lateral curvature of the spine, instead of by exercises and other measures improving the musculature of the back. In ingrowing ankles also the musculature must be improved, especially the tibialis posticus. This should not be done as the superannuated soldier teaches boys, with the toes turned out; but with them pointing straight forward, or even turned a little inwards.

The next deformity associated with the resting position of the foot occurs at the metatarso-phalangeal joint; is that very common deformity *hallux valgus.*

(*a*) Delivered at the Medical Graduates' College and Polyclinic, London. 1907.

Here I show you a slide of hallux varus, which is associated with the active position of the foot. Hallux valgus is usually attributed to badly-shaped boots; but this is not always so. If you examine such a foot whilst inside the boot you will often find quite an interval between the toe and the inner portion of the boot. Hallux valgus is a part of the abducted position of the foot, and as a result of that, the inner side of the head of the first metatarsal is pressed against the boot upper; and whenever a bony point is pressed or rubbed against a firm thing like the upper of a boot, it develops a bony boss on that surface, and so the toe will be pushed into a position of hallux valgus. The operation usually done consists in removing this bony boss, and passing a tenotome through to divide the contracted ligament. (*a*) It is common for people to forget to divide that ligament, but if that is not divided, the toe will not go into place. After doing that operation, warn the patient that the toe will not stay in the position in which it has been placed, but with the removal of the piece of bone and bursa it will probably be painless. In every case of hallux valgus a certain amount of attention should always be given to the boots worn. The usual idea is that these people should wear broad-toed ugly-looking boots; but that is quite unnecessary. As a sort of rough-and-ready test you can estimate whether a boot is right or not by drawing a line parallel with the inner margin of the boot. If it is a well-made boot this line will pass through the middle of the heel.

Now I want to say a word about *hallux rigidus*, particularly in association with the inactive or abducted position of the foot. This is the form usually described in the text books and shown in the out-patient room. In this condition, as you know, the big toe stands out, and is stiff and painful. Hallux rigidus, as ordinarily described, can be bent towards the sole of the foot, but not in the contrary direction. That is the distinction between hallux rigidus associated with the active as compared with that of the inactive foot. The proximal phalanx of the big toe moves round the head of the metatarsal bone in an arc of a circle, the radius of which is the lateral ligament of the joint. If on the dorsum of the head of the metatarsal a bony boss forms, it will slowly push the phalanx, so that the toe gets bent upwards. In the inactive foot, pressure is not borne there. The callosities of the sole of the abducted foot are under the third toe, not under the big toe. But in the inactive foot it is the upper part of the head of this metatarsal which is driven against the boot upper. As the upper part of the bone enlarges, the ligament will be tight, and the toe will be more and more bent in towards the sole of the foot. This slide shows hallux rigidus not as ordinarily described; the bony boss is on the lower surface of the metatarsal, not the upper; and as the deformity grows, the phalanx will become dorsally flexed, so that it curls up backwards. This is hallux rigidus of the active position of the foot. As the bony boss on the upper part of the metatarsal continues to grow, and the big toe becomes more and more flexed into the sole of the foot, there arises the condition described as hallux flexus. If it requires any treatment it is almost invariably amputation at that joint. The next slide shows hallux extensus, and it is associated with the active position of the foot. The bony boss is developed on the under-surface, so leading to the dorsiflexion or extension of the toe. Such a condition will lead to a transverse crease developing in the upper of the boot. The first line of treatment of this is by means of exercises, which may be combined with passive manipulation of the toe. In teaching such exercises, as tip-toe exercises in hallux rigidus, it is well that they should be begun with the toes turned outwards; then the toes should, every day or every two or three days, be turned a little more in, until finally, if the exercises are going to cure it, the patient should be able to perform them with the toes turned in. With regard to operative treatment in such a case, when it is associated with an inactive foot, with the bony boss on the head of the metatarsal bone at the top, you need have no scruple in taking away the head of the first metatarsal. That seems a severe piece of advice, when it is remembered that the great stress falls on the first metatarsal; but that is untrue of the inactive or abducted foot, and it is in this that the ordinary hallux rigidus of the textbooks occurs; and in those cases the under-surface of the head of the metatarsal bears no pressure during walking, therefore its loss will not be much felt by the patient. The next slide shows that the bony boss on the head of the first phalanx formed at the lower part, and a bursa, and then a corn, and the distal phalanx is extended or flexed towards the dorsum of the foot. In that case you find a corn under the head of the proximal phalanx. It is not uncommon to see in the out-patient room a corn not under the ball of the big toe, but under that toe more distally. When that is the case one can be certain that the foot is habitually in the inactive position. For this deformity I suggest the name *digitus extensus*.

This slide shows hallux valgus, and in that the valgus takes place partly in the metatarso-phalangeal joint, and partly in the interphalangeal joint. In the next slide the phalanx is affected at the interphalangeal joint solely. So it is a case of *digitus valgus* of the great toe.

The next slide shows ordinary hammer toe, and the deformity there is the same as that which I showed under the name *digitus flexus* of the great toe. The general operative treatment consists in making a lateral incision through the skin, dividing the lateral ligament at the interphalangeal joint, and removing the head of this proximal phalanx. If it ever was necessary, as it very uncommonly is, to operate on a case of digitus flexus of the great toe, then a similar lateral incision is made, and the head of the proximal phalanx will be removed.

And now I want to say a word about ingrowing toe-nail. It is a very common condition, and I want to point out the many reasons why it is commonly associated with the abduction or the inactive position of the foot. The ingrowing toe-nail, especially early cases, can be cured by ordinary local cleanly treatment, and the treatment for the abducted position of the foot, by which I mean tip-toe exercises, with the toes turned out, but with the foot directed straight forward. In very few of these cases is it necessary to proceed to operation, but where that is required, these slides show what should be done. Half the nail and the matrix are removed, and the wound sewn up (*a*).

It had been my intention also to speak about deformities of the leg and elsewhere which one finds associated with the abducted position of the foot.

People whose feet are in the inactive position, if they fall on their feet, are far more liable to injure them, and to break a bone, particularly the second or third metatarsals, than are people with adducted feet. In these cases one is apt to find pain and tenderness persisting for a long time about the base of the third metatarsal bone. It is very difficult to know why this pain persists; one is apt to think some more severe injury has been overlooked. Skiagrams do not help us much in this matter, because they do not show us distinctly the parts in the region of the base of the third metatarsal. In an abducted foot, it is difficult to state whether the lesion about the base of the third metatarsal bone is fracture, or a partial dislocation, or an injury only, of the soft parts, which is called a sprain. If one starts massage and exercises as soon as it can be done, one knows that that injury will get well in two or three months. Still, the patient usually suffers from some disability all his life. If he be a labouring man, he is not able to stand so long as he formerly could, or he is not able to go up a ladder as well. Thus there is something taken off his wage-earning capacity. These cases should be borne in mind and understood, because they often figure in legal actions against employers.

(*a*) "Operations of General Practice." Pp. 245-246.

(*a*) "Operations of General Practice." Pp. 246-247

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by R. L. Swan, F.R.C.S.I., Surgeon to Dr. Steevens' Hospital and to the Orthopædic Hospital, Dublin. Subject: "A Reference to Some Tubercular Diseases of the Knee-Joint, and to the Treatment of the Synovial Cavities."*

ORIGINAL PAPERS.

DEATH FROM HÆMORRHAGE FROM A MEDICO-LEGAL POINT OF VIEW.

PART II.

BY PROFESSOR HENDRICK, M.D.,
Of Hamburg.

(Specially reported by our German Correspondent.)

Continued from page 494.

II.—DEATH FROM HÆMORRHAGE IN CONSEQUENCE OF SOLUTION OF CONTINUITY OF THE GREAT BLOOD VESSELS.

Death from solution of continuity of the great blood vessels, aorta, innominate artery, pulmonary artery, inferior and superior vena cava, is not frequent, as they lie in a position specially protected by the sternum.

When they are wounded, death, as a rule, follows very quickly—more quickly than when the heart is wounded (as Richter showed in his experiments on animals), as the blood finds less resistance in the adjoining tissues, and in consequence of the impossibility of assistance it flows uninterruptedly.

The bleeding takes place into the mediastinum, and after bursting into the pleura, into the pleural cavity, or when the abdominal aorta is injured, into the abdominal cavity. By compression of the lungs, as shown by Richter's experiments on rabbits, the bleeding is somewhat checked, but it has never been observed that this has ever had any influence on the rapidity of the course. Pneumothorax may be associated with the hæmatothorax that is set up. As regards the causes, besides the traumatic, spontaneous rupture may take place, or rupture from very slight force, especially in the case of the aorta (rupture of the aorta). These are caused by morbid changes of the arterial walls, arteriosclerosis, fatty degeneration, endarteritis, aneurysm, the extension of ulcerative processes from adjoining parts (cancer of the œsophagus, caries of the vertebræ, foreign bodies that have stuck fast in the œsophagus).

If the rupture affects the whole three coats of the vessel, the bleeding is more rapid. The favourite place for rupture is just over its commencement. Generally the rupture is transverse. If only the intima and media are affected, a dissecting aneurysm may form, and the bleeding may be interrupted by it, but only for a short time generally—a few hours to a few days. The adventitia at last yields to the pressure of blood, and death from hæmorrhage takes place. If the vessels are healthy, only extraordinary violence can cause them to rupture. A case described by Langenbeck of rupture of the aorta without disease of the vessel is an exception, where a perfectly healthy person at a trial in court suddenly collapsed from rupture of the aorta (quoted from Drenckheim). Proof or a causal relationship between rupture of an aneurysm of the aorta and an earlier violence that has been followed by an aneurysm is extremely difficult to establish. Thus Pantzer describes a case where the question for decision was: Had the aneurysm that caused the death any causal relationship with an accident that happened seven years before? The three opinions that were given by three different experts did not agree as to the cause. As most aneurysms develop without any demonstrable cause, an aneurysm that leads to fatal hæmorrhage may at most, with some degree of probability, but not sufficient for a judicial decision, be traced back to a former injury.

Bleeding to death from solution of continuity of the sub-clavian vessels is, according to Israel, extremely rare, and this is attributable to their protected position. It is distinguished from that before described, in so far that it may be either internal or external, and assistance may possibly be rendered. The internal hæmorrhage runs the same course as that of the great cardiac vessels before described. When it is external its course may be retarded by the blood making its way under the muscles, and the formation of a clot. Death takes place from the hæmorrhage alone, or associated with air embolism with its resulting suffocation (complicated death from hæmorrhage). The course of the bleeding may be interrupted by the formation of a spurious or varicose aneurysm, that ruptures suddenly and leads to death. If, after professional assistance has been rendered, death takes place from late hæmorrhage, it is, according to Maschka, the business of the medico-legal expert to decide how far the injury itself caused the death, and to mark how far improper behaviour on the part of the wounded man himself, how far the professional treatment or any accidental wound contributed to the late onset of hæmorrhage. Here it may be a question of neglect on the part of the surgeon; but as Sachs specially notes, it is to be borne in mind that, in spite of the omission of a surgical operation, which must have been a considerable one, the patient would not be saved. Cases of this kind are given by Seydel (Kasuist. Mitteilungen aus der forens. Praxis, Vierteljahrsch. f. gerichtl. Med., Bd. XLIII.), and by Nussbaum (Friedrich s. Blätter f. gerichtl. Med., 1876, S. 146).

Bleeding to death plays a great *rôle*, from a medico-legal point of view, in the frequently occurring deaths from the throat being cut in cases of murder and suicide. If the carotid is wounded, death takes place in a short time, as the blood can flow outwardly without check. If, as happens in most cases, the trachea is opened, the blood flows from the superficial vessels (the external jugular and the superior thyroid artery and their branches), as well as from the deeper ones, into the respiratory passages, and suffocation ensues before the patient bleeds to death. The great veins of the neck being opened also, air may enter, and death be caused by air embolism. The case is therefore one of complicated death from hæmorrhage from blocking of the air passages or from air embolism. The quantity of blood which continues pouring out from the body until death cannot be measured; in any case of death with this complication a much smaller loss of blood leads to death than in ordinary cases. The decision of the question as to the deed, whether murder or suicide, frequently presents difficulties. The following may be taken as general criteria: The suicide stabs from above on the left downwards towards the right or from above on the right downwards to the left, according as he is right or left-handed. Often from repeating the stabs, or from the skin falling into folds from involuntarily bending his head, he will show several incised wounds; whilst in murder, often committed whilst the victim is asleep, there is more generally one deep and more horizontal wound. The suicide will sometimes show secondary incisions on other parts of the body from unsuccessful attempts; he will have the weapon in his hand, and this will be bloody. On closer consideration of these criteria, we must concede that Puppe is right when he says:—"The differential diagnosis in cases of death from cut throat between murder and suicide offers a remarkable uncertainty, whatever the circumstances may be. A series of distinguishing signs are usually present in murder cases, but there is not one that has not been observed in suicide cases also, and *vice versâ*."

Bleeding to death from wounds of the large vessels of the lower extremities occurs the most frequently of any of the kinds hitherto described; it is especially the subject of medico-legal inquiry, as suicide from wounds of the arteries. It is distinguished from death from hæmorrhage from injury of the subclavian artery in being more accessible to assistance either by the injured party himself or by others; its course may therefore be interrupted, but if the aid is not speedily on the spot, the end comes quickly. Moreover, in spite of professional assistance, death often takes place from secondary hæmorrhage.

Bleeding to death may also occur from injury of superficial veins. Thus Caspar-Liman mention a case

(Kasuistik, No. 128), in which a person rising from a broken night commode injured the saphena vein and bled to death. Schlag also reports a case of a person who bled to death from an opening in the saphena vein of the right leg, which had been made with the intention of committing suicide. Bleeding to death was rendered possible here by the vein being varicose and adherent to the periosteum.

Leonpacher (Aerztl. Sachverst.-Zeit., 1898, No. 5, S. 99) cites a further case of the kind, where a woman in a railway carriage bled to death in 13 minutes from a vein that had burst without knowing herself that she was bleeding.

Bleeding to death may also occur from smaller vessels than those mentioned, but unfavourable conditions are usually necessary, especially a morbidly diminished power of coagulation of the blood (hæmophilia). In the latter cases even a slight injury may cause fatal hæmorrhage (extraction of teeth, epistaxis, etc.).

Fatal hæmorrhage may take place from parenchymatous bleeding from injuries of the corpora cavernosa, the tongue, and the spongy bones. Injuries of the corpora cavernosa occur principally from attempted rapes and injuries of the female genital organs which will be described later. In fatal hæmorrhages from the tongue, the fatal termination is mostly complicated by the blood finding its way into the lungs and causing suffocation, but the fatal result may follow from external hæmorrhage only (Colley) (32).

Fatal hæmorrhage from parenchymatous bleeding is almost always internal. In diseased organs it may be spontaneous or from only slight violence, but in healthy organs only from the effects of considerable force. The following have been observed: being run over, falls from a height, crushing between fixed or moving objects, a blow, a push, or a fall. The diagnosis can only be determined on opening the body, especially in the not rare cases in which the body shows no external marks of violence. For determining the diagnosis—whether of spontaneous or traumatic origin—the situation and direction of the opening are of value; if spontaneous it will be found at the spot where experience teaches the disease is by preference localised, whilst in traumatic ruptures certain physical laws will be followed as to size, consistency, position (whether protected, etc.), the form of consolidation, the condition of the hollow viscera as to fulness, and the form of rupture. In the meantime the points of predilection for rupture of organs as determined by experiment are more important from a scientific than from a practical point of view (see Geill) (35).

More in detail to be discussed are fatal hæmorrhages from ruptures of the brain, liver, lungs, spleen, kidneys, pancreas, stomach, intestines and bladder. Ruptures of the heart and aorta have already been treated of. Ruptures of the female genital organs will be treated by themselves.

Fatal hæmorrhage from bleeding into the cranial cavities from the venous blood vessels, the meningeal artery and its branches, the basilar artery and its ramifications (intra-cranial hæmorrhage), may appear under very varied aspects from a medico-legal point of view. The simplest cases to determine are those in which there has been fracture of the skull, laceration of vessels, cerebral hæmorrhage, or rupture of the brain, fracture of the skull being a certain sign of traumatism. Death takes place from paralysis from blood pressure, and generally not immediately after the injury, but after a certain time—hours, sometimes even days—have elapsed, during which the signs of pressure gradually increase; or also directly from breaking up of brain substance, in which latter cases there are transitions in the mode of death from crushing of important organs. It is important here to observe that signs of external violence may be altogether absent, and that the part injured does not always correspond to the part where the violence has fallen, but frequently lies quite opposite to it (contre coup). Those cases are more difficult to determine, but also more rare, in which vessels are torn or even the brain lacerated without any fracture of the skull being present. Zaajer describes such a case (36), where a woman aged 38 died from laceration of the brain without any fracture of the skull, probably after being abused by her husband; the man, however, in the absence of legal proof, got off. Defraneschi (38) (Aerz. Sachverst. Ztg., 1902, No. 7), mentions a case where a countryman received a blow on the head. The next day he became unconscious and died in 24 hours. The autopsy showed laceration of the middle cerebral artery and effusion of blood without any fracture of the skull.

The mechanism of these injuries, according to the experiments of Bruns, Baum, Messers and Treub (7), is as follows: The elastic skull is compressed by the violence by which the cerebral fluid is forced back into the cavity of the spinal cord; after the cessation of the violence the skull springs back quickly, the fluid cannot move so quickly, and a negative pressure arises within the skull, whence the rupture. The place of rupture may be in any part.

Those cases are most difficult to determine in which there is disease of the walls of the vessels—arterio-sclerosis, small miliary aneurysms (Hofmann), vascular internal pachymeningitis, which may have caused spontaneous rupture, but in which there has been a possibility of a traumatic origin.

These cases are frequently the subject of legal proceedings when property is in question (Schilling) (37), where violence may be asserted when there has been none, or of so trivial a nature (a box on the ear) that for the first moment one doubts the deadly effect. The number of possible origins in these cases is great. A box on the ear may be fatal when the skull is thin, a blow of the fist, if there is an aneurysm, a fall from slipping may be fatal because the man is a drinker with arterio-sclerosis. The decision will be still more difficult when death does not follow the suspected incriminating event immediately, but later, as the following example from a collection of medico-legal opinions from Vienna shows: A woman was struck on the head with the fist, possibly also with a closed knife; she fell down, and remained several hours on the ground, got up again and walked away; possibly also she again received blows on the head. The morning after she was found dead in bed. Post-mortem examination: superficies of the brain covered with blood. The question was: did she die from violence, a blow, a fall, a push, or was she thrown, or was it in consequence of lying on the cold ground in a drunken condition, or after the excitement of a fit of rage? In a similar case, where a blow on the head, brandy, and struggling had caused extradural hæmorrhage and bleeding between the cerebral hemispheres, a ruling opinion was given to the effect that the brandy and the struggle were secondary causes. Another case in which apoplexy had taken place in consequence of leucæmia, shows how easily an inconspicuous trauma may be taken as the cause of the hæmorrhage in such cases.

The differential diagnosis between spontaneous and traumatic hæmorrhage may be determined according to the following criteria (Schilling) (37):—

(1) Spontaneous hæmorrhages are mostly central, and spread from within outwards, and have a known seat which, according to Andral (quoted in Schilling), was out of 386 cases 61 times the corpora striata, 35 times the optic thalamus, 27 times the centrum ovale, and the ganglia 202 times. They mostly proceed from the branches of the artery of the fissure of Sylvius, and pathological changes of the vascular system are found in other parts.

(2) In traumatic hæmorrhages without fracture of the skull there are dural, sub-dural, or arachnoideal hæmorrhages in one large or several small collections. If central extravasations are present, they are always accompanied by bleeding from the meninges. V. Bergmann decided in a case where a drunken man was struck to the ground, that the absence of meningeal extravasations with a central one in the interior was in favour of a spontaneous origin.

Fatal rupture of the liver always takes place when the lesion is of a certain extent. Death after the injury may not be rapid, as might be expected where the blood has free exit into the peritoneal cavity. In a case observed in v. Nussbaum's klinik (quoted from Drenckhahn) (26), a man who had been crushed between wagons, and after this injury walked to the hospital six hours afterwards, died from a large rent in the right lobe of his liver. According to Puppe (26), rents are distinguished according to their situation, in the convexity, at the base, and sub-capsular. The liver tears from contusions most readily of all the organs of the body in consequence of its size and its method of fixation, its dependence in firm ligaments, The blunt injuries that cause the liver to give way are, according to their frequency, the following (Heinzelmann) (13): the most frequent is being run over; next a push; thirdly, falls from a great height, from a horse, a wagon, and such contusions. It is indubitable that pathological processes make the liver more likely to tear under the influence of slight degrees of violence (Geill) (35). In a case mentioned by Chiari (11), a carcinomatous liver ruptured from turning in bed. Heinzelmann (9) reports a case of rupture of the liver that could have arisen from turning in bed or from a forced inspiration. In two other cases one was from a fall on the right side (tuberculous omentum), the other from a fall on the ice (tuberculous diathesis). Fischer (11) states that ruptures of the liver are seen from slight blows over echinococcus cysts; Taylor (11) is of opinion that a liver with fatty degeneration may rupture from contraction of the abdominal muscles. Lidell, Strassmann, and Hofmann express themselves to the same effect. According to the Handbuch der Chirurgie, by v. Bergmann, tuberculosis, syphilis, and amyloid predispose to ruptures. Experiments made on dead livers with regard to friability or firmness (Caspar-Liman, Ogston, Strassmann) have not led to any uniform results of practical value. In the same way no special direction of rupture after contusions, as compared with spontaneous rupture, has been determined. It can perhaps only be said that amongst the kinds of rupture the sagittal in the middle part preponderate.

Ruptures of the lungs come in the second line as regards frequency of occurrence. Fatal hæmorrhage from rupture of the lungs takes place from every moderately severe injury of them. It is mostly complicated by bleeding into the opened air passages and consequent suffocation, which when the force is great follows immediately with formation of hæmato or hæmato-pneumothorax and subsequent compression of the lungs. The lungs being so well protected against injury by the chest walls, for rupture to take place the larynx must be closed through fear at the moment of compression, when the lungs burst like a bladder filled with air, naturally at some locus minoris resistentiæ, caused by disease. As to the direction of the rent morbid conditions of the lungs have less influence than pleuritic adhesions (Altmann) (41). The principal line of rupture is longitudinal along the posterior inner margin of the lungs, the next hilus rupture, rupture between the lobes. It is also to be noted that ruptures may affect the inner parts of the lungs only, without being visible externally, and these may arise from purely internal causes, so that from the condition found there may be nothing to indicate external violence (Caspar-Liman).

In injuries and ruptures of the spleen, which in regard to frequency occupy the third place, the hæmorrhage is generally fatal, either immediately or from an intervening cause (peritonitis), as is shown in statistics collected by Heidenhain (42). From statistics by Edler (quoted from Handbuch by v. Bergmann) of 44 ruptures, 42 were fatal, 39 from hæmorrhage, 3 from peritonitis. Death does not always take place rapidly, but in a case of Schwing's, for example, half an hour after the rupture in a pregnant woman, in a case reported by Tomkins (*Lancet*, Jan. 4th, 1881), three weeks after. Ruptures of the healthy spleen are very rare on account of its protracted situation, provided the force acting on the abdomen is not actually a crushing one. Sometimes they occur in new-born infants from manipulations during birth. The pathological conditions that cause the spleen to give way easily are infarctions, acute swellings from infective diseases, particularly typhoid, chronic enlargements of it from venous stasis, disease of the heart, cirrhosis of the liver, and especially malaria (important in malaria districts). Playfair (7), in the course of two and a half years in the East Indies, saw more than 20 cases of rupture of the spleen; he states that in those parts one-third of the whole population suffer from enlargement of the spleen. As causes that bring about rupture of the unhealthy spleen, violent muscular contractions of the abdominal muscles and of the diaphragm are mentioned (v. Bergmann's Handbuch der Chirurgie), for example, violent sneezing (Silberstein), vomiting (Kering). Even palpation of a splenic tumour in a cachectic individual may cause rupture of it (Colin). In order to explain the mechanism of rupture of the spleen, one must look upon it as a hollow organ filled with fluid and suspended by ligaments (Geill). Rupture from violence is usually transverse, and in the neighbourhood of the hilus. This direction is dependent on the manner in which the spleen is suspended by its ligaments.

Ruptures of the kidney take rank as regards frequency in the fourth place; as isolated injuries they are rare, as the kidneys are well protected by muscles, connective tissue, and fat, and also by the vertebral column (Geill). They occur most frequently along with other injuries from being run over. Hofmann (1) mentions a case in which a medical man, going quickly, ran up against a wooden barrier, which caused fatal hæmorrhage from the kidney. Mittenzweig (Zeitsch. f. Med. Beamte, 1893, S. 616) reports a case of traumatic bleeding from the right suprarenal capsule, 24 hours after the patient had got caught between the buffers of railway wagons; the bleeding was internal, and was caused by rupture of the vessels of the right suprarenal capsule; there were also fractures of ribs, of a clavicle and thrombi of the middle intercostal arteries.

In injuries of the kidneys ending fatally, according to statistics collected by Kuster (Kuster, Die chirurgischen Krankheiten der Nieren, Deutsche Chirurgie, Liefg. 52b), death takes place from hæmorrhage in almost half the cases (in 30 out of 67 cases), and mostly from secondary hæmorrhage during the first four weeks, or from rupture of an aneurysm that has formed. From a medico-legal point of view it is important to know this.

Ruptures of the pancreas are less frequently traumatic than spontaneous from disease—mostly fatty degeneration—and may cause death from the bleeding that takes place (pancreatic apoplexy). Various views prevail as to the nature of pancreatic hæmorrhage. Zenker (11) looks on it as the cause of sudden death; Reubold (11) as a symptom of circulatory disturbances that have themselves caused death (Sachs). Kratter (45) investigated 33 cases, and came to the conclusion: "Pancreatic hæmorrhage is not the cause but the consequence of sudden death, and is not very rare when death is sudden. It has a diagnostic significance, inasmuch as it indicates a cause of death in which an agonal trauma occurs (spasm of the diaphragm), which affects the abdominal salivary glands." Further observations are necessary for the clearing-up of this question.

Injuries and ruptures of the hollow organs lying in the abdominal cavity, the stomach, intestines, the bladder, as well as all other organs carrying vessels—the mesentery and omentum—may all lead to death from hæmorrhage. Tuberculosis, ulcers of the mucous surfaces (round ulcer of the stomach, typhoid ulcer of the intestines, dysenteric ulcerations), all predispose to ruptures. For their occurrence it is necessary that a part of the gastro-intestinal canal shall be over-full of liquid, semi-liquid, or gaseous contents, and be forced against a solid body—the vertebral column—and kinked at the side so that the contents cannot escape. According to the laws of hydrostatics, rupture must then take place, and must always be at the weakest or diseased part. The following have been observed to cause fatal intestinal hæmorrhages: The lifting of a cask (Hankel) (48), a blow of the first against the abdomen (Bodgan) (49), manipulations during labour (Ciechanowsky) (50), and others. Friedberg (14) mentions a case of fatal hæmorrhage from the stomach from the improper use of an emetic. Dr. Graetz-Sobbowitz (52) (Aerztl. Sachverst.-Zeit., 1900, No. 5, S. 95) reports a case of fatal intestinal hæmorrhage from an accident in which a workman was engaged in lifting an iron rail with a lever, when the lever slipped, and he received a blow on the abdomen with it; he fell forwards, and by the evening was dead. At the autopsy a good deal of hæmorrhage was found between the layers of the mesentery, and the small intestines were also filled with partly fluid blood.

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(To be continued.)

A GENERATION'S OBSERVATION OF DISEASE. (a)

By JAS. ORMISTON AFFLECK, M.D. Ed., F.R.C.P.,

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Dr. Affleck remarked that since he first studied medicine great changes had occurred. The science of bacteriology had arisen, and had shown us the cause of many diseases, while in the more recent researches into immunity we were discovering the exact nature of many morbid processes. The chemistry of digestion had also thrown fresh light upon many of the most important diseases the physician encountered, while the introduction of

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(a) Abstract of President's Valedictory Address, delivered before the Edinburgh Medico Chirurgical Society, November 6th, 1907.

Röntgen rays was an instance of the fruitful application of physics to medicine, and the same science had given us means of investigating the blood pressure, and the various methods of applying electricity in diagnosis and treatment. The study of the blood, too, had resulted in many valuable additions to our power of diagnosing morbid processes. He believed, however, that the older amongst his hearers, in particular, would bear him out as to the valuable information that could be derived by simple observation of patients. He did not mean only the facies of disease, but used the word physiognomy with a wider meaning, to include all the signs which were visible to the unaided senses

Take, for instance, cough. We could distinguish the short, suppressed cough of pneumonia, the dry, irritable cough of early phthisis, the hysterical cough, the barking cough of puberty, whooping cough, the clanging cough of ultra-thoracic pressure, the cough of chronic bronchitis, and he believed also that the cough of pyopneumothorax had a character of its own. Simple observation of the phenomena of disease, such as these, gave information of great value, and out of many instances which rose to his mind he might cite the case of a young clergyman who entered the consulting-room with the complaint of chronic indigestion, vomiting, lassitude and headache. Watching him as he spoke, the pearly glistening of the conjunctiva attracted attention, and led to an immediate examination of the urine, which showed that Bright's disease was the cause of his symptoms. Again, a business man who had always enjoyed the best of health presented himself for life assurance. It was noticed that his hair was rather dry and scanty, and there was a dull, pinkish, malar flush. These aroused the suspicion that he had diabetes, and this was found to be the case.

In typhoid fever, again, the patient's expression was often characteristic. In the Fever Hospital he noticed that the first note that his friend Dr. Ker made on the case of a newly-admitted patient was whether he "looked like" typhoid fever or not. As a result of experience, a physician gradually acquired what, for want of a better word, he would term "clinical impressions." Some possessed the faculty much more than others, and it was one of the most valuable assets it was possible to acquire. By clinical impressions he meant something which was quite uncommunicable to others; the physician himself could not tell why or how they came—they were the unconscious result of comparisons and recollections. Such impressions had often been of the greatest service to him both in suggesting to him fresh lines of treatment which had often proved successful, and sometimes in encouraging him to offer hope where the circumstances seemed desperate. Such impressions sometimes led one astray, but they were, nevertheless, of the greatest value, and the faculty of acquiring them ought to be developed as far as possible.

Next he wished to speak of the psychical aspect of disease, and of the importance of trying to discover what was in the patient's mind. It was hardly too much to say that there was no disease but had its effect on the patient's temperament. In some we found illness causing irritability and fretfulness, while in others the reverse change occurred, and the busy, restless, energetic man became an example of patient fortitude. Mental processes had a profound effect on the body; he instanced, as a case in point, a young girl in his ward whose constant high temperature aroused great anxiety until her appearance of well-being had suggested its hysterical origin. Subsequent events showed that it was one of those rare cases of hysterical hyperpyrexia.

The importance of mental effect in therapeutics was shown by the well-known story told of Sydenham. Having a patient whom no efforts of his could cure, he told him that there was only one physician who had made a study of his complaint, Dr. Robertson, of Inverness. The patient decided to seize this hope of cure, and posted the distance of six hundred miles, armed with a history of his symptoms, and an introduction to Dr. Robertson. When he arrived at Inverness he learned, with dismay, that not only did no Dr. Robertson live at Inverness, but that no practitioner of that name had existed there within the memory of the eldest inhabitant. As enraged at the deception which had been practised on him as he had been hasty in setting off on his journey, he hurried back to London and upbraided Sydenham. "But you appear better," said the doctor. "Yes, I'm better," replied he, "but no thanks to you for it, Dr. Sydenham." "You are better, thanks to Dr. Robertson, of Inverness," answered Sydenham; "I wished to make you travel with a definite interest, and I made you go to Inverness with the object of consulting Dr. Robertson, and travel back to London in order to abuse me." He could only see what was passing in a patient's mind by the exercise of the gift of sympathy, so that the cultivation of this should be one of our objects. If it were important to study the patient's thoughts, it should equally be remembered that the patient would study the doctor's face, and many were quick to perceive what was in his thoughts. It was only when he could detect sympathy and comprehension that he gave the physician his entire confidence, and without the patient's confidence it was difficult, or impossible, to do him good.

A PRELIMINARY NOTE ON A

SIMPLE OPERATION FOR UNCOMPLICATED OBLIQUE INGUINAL HERNIA IN YOUNG ADULTS (a).

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OBLIQUE inguinal hernias in children being admittedly of congenital origin, and due to the existence of a preformed sac, partial or complete, and ligation of the neck of the sac at the internal ring having been proved to be an efficient line of treatment, it is justifiable to suppose that if in young adults oblique inguinal hernia is also of congenital origin—*i.e.*, due to the existence of a preformed sac, a similar operation will prove satisfactory. The operation devised for the purpose consisted in an incision over the internal abdominal ring about half an inch above Poupart's ligament, with successive division of the muscular layers, exposing the neck of the sac, which was then divided and ligated. The second stage in the operation consisted in union of the wound, without an attempt to close the inguinal canal, or to remove the sac, and without interference with the integrity of the normal function of the internal oblique and transversalis muscles. Evidence from various sources was put forward to show that there was no essential difference as regards origin between so-called acquired oblique inguinal hernia which developes gradually, and the congenital form, which develops suddenly. In both classes of case it was argued that a preformed sac existed. Murray's observations on cadavers showed that in a considerable proportion of cases, where hernia had never occurred, there yet existed a passage large enough to admit a probe along the inguinal canal. The internal ring was normally closed by the valvular action of the internal oblique and transversalis muscles (as could readily be appreciated when, during the operation, the patient came out of the chloroform to some extent and began to strain), and it was held that, provided the sac was effectively dealt with, the natural function of these muscles would be regained and would be amply sufficient to maintain the closure of the internal ring. On the other hand, operations which involved suturing the internal oblique and transversalis with a view to producing closure in this way, interfered with the normal function of the muscles and the natural mechanism occluding the ring. The operation was devised for young adults, and the limit of age at which it could be performed with a good prospect of success depended on the tone of the muscles of the patient. The advantages of the operation were the absence of complications arising from manipulation of the sac and scrotum, and, owing to the position of the incision, the diminished risk of contamination. It was not necessary to keep patients in bed more than a fortnight or three weeks. As soon as the wound was firmly united it was better to allow them up so as to restore the function of the muscle closing the ring. The principle was insisted on that in oblique inguinal hernia a preformed sac was a necessity, and that unless this was present the internal ring would be kept closed by the valvular action of the muscles. From this it followed that the sac being closed, the normal muscular action would reassert itself. Operations which attempted to cure hernia by suturing the pillars of the ring, &c., deviated from this principle, and did not sufficiently take account of Nature's method of occluding the inguinal canal. Reference was made to a number of cases in which the operation had been followed by a satisfactory result.

(a) **Abstract of paper read before the Edinburgh Medical-Chir. Socy., Nov. 6th, 1907.**

THE LIMITATION OF MORTALITY FROM TUBERCULOSIS.

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An experience of forty years of tuberculous disease may justify me in expressing views of its nature, even though my knowledge of the literature bearing on it is extremely defective, in part from want of access to its vast and ever-increasing mass. Under the condition, there may be nothing new in what I have to say; it may be all a many-told tale, but, if so, it certainly is not adequately represented in the body of opinion which constitutes current formal doctrine, that which every medical man and every medical student is expected to know.

If that formal doctrine was simply speculative and academic, it might be allowed to pass; all our judgments are more or less of the nature, even where the necessity of action compels us to select one judgment, discarding or ignoring others. It is one thing, however, to do so consciously, another to do so at the expense of consciousness of what is ignored. The proposed, and far more than proposed, "war on the white scourge" is an instance of this; we form a judgment under some preconception, of the necessity for action against tuberculosis, but the merit and necessity of the action do not at all make the judgment a necessary one; it is in reality only one with many alternatives, which we have no right to discard or be ignorant of because they do not give us grounds for action, or grounds not at all sufficient to justify a vast expenditure of public money.

The position is not new; we have had experience of it in the past, and of the futility of a judgment based on imperfect knowledge. For long enough medical men stood helpless before small-pox. It might satisfy the anti-vaccinationists to say that the right thing was to have initiated a sanitary campaign against the scourge, isolation hospitals, sanatoriums, and so on; but that would have satisfied Sydenham as little as his successors nowadays. A sanitary campaign would have been all very right on general principles, but medical men would never have committed themselves to the opinion that it would have prevented or arrested epidemic small-pox. They would not commit themselves now to the opinion that, in the absence of vaccination, it would not occur, however perfect the conditions of sanitation might be. They would hold that isolation and isolation hospitals only met the case of the disease as it actually occurred, and had limited efficacy in preventing it spreading. What was early seen was, that it was limited by its own incidence, that experience of it was the most effective means of controlling the mortality from it. The adoption of inoculation rested on the observation that the disease was not a fatal one for the mass of persons under ordinary circumstances, that its fatality depended greatly on it selecting certain persons under certain circumstances. The general conclusion arrived at was that the fatality was a minimum in proportion as the experience of the disease was a maximum, and the conclusion was sound enough to base the practice of inoculation on. Looking on vaccinia as a modification of variola, the principle holds good for the artificial induction of the disease as the most effective means of controlling its mortality.

The received doctrine in respect of tuberculosis is that it is, unlike small-pox, a persistent morbid state, but I would suggest to the thinker on the subject to contradict tentatively every article of his faith; it is no sin to do so. We cannot say that small-pox is not a persistent state; it leaves behind a state of body which is certainly not the original one, as evidenced by loss of susceptibility to the disease. We do not call the new state morbid, although there may be no essential difference between it and the states we do apply the term to. Again, small-pox does persist as changed states of the skin and other organs in very gross form. That, of course, we put in a different way, but we cannot always draw a line between a disease as a primary affection and what it leaves behind—distinguish clearly between them. In the next place we may contradict the position that tuberculosis is a permanent morbid state in the sense small-pox is said not to be. Its typical form may be stated, in respect of invasion and course, as not in any essential respect different from typical small-pox. The form, fortunately comparatively rare in the human subject, is best seen when induced experimentally in susceptible animals. It is in both cases rapidly and more uniformly fatal than small-pox. How, then, does it come that a disease of such character is, relatively to its prevalence, under extreme limitation with respect to the mortality from it; in what direction are we to look for the restraints on its mortality?

In the present state of our knowledge of it, several answers may be given to the question which, though not very satisfactory, are taken together inconsistent with the doctrines at present in fashion. If we go back to the older writers we will find that they do not affirm, or deny, or were ignorant of, in a general sense, an initial cause for the disease, a contagious or infective agency which they were unable more precisely to define What, however, they had clearly in mind was, that certain morbid processes, once set up, were self-acting—had continuous operation independent of the exciting or contributory cause. What they said or supposed was, that a certain medium was the first and necessary condition of zymosis, and that the spoiling of the medium, say, the blood, or an element in it, under zymosis, led, in the case of tuberculosis, to a specific exudation from the blood. It was, however, only natural and logical, going back to what is now called the nutrient germ medium, to hold that it varied of itself independently of any extraneous agent exciting zymosis, and that diseased states, quite apart from zymosis, would arise from change in it. The case was not that of an organic fluid sealed up in a tube and found stable under the condition; the fluids in the actual case are undergoing metabolism from instant to instant in presence of a host of causes which might vary or derange the operation. Thus the old is a general position allowing the modern one of germ action as a particular case. The particular case meant that the medium was normal for the zymosis, but that did not mean that it was physiologically normal; the very state that favoured zymosis might be the true pathological antecedent and explain what is meant by predisposition. But the pathological antecedent is capable of morbid development *per se;* it is the essential factor, the zymotic operation, particular itself, only gives it some particular modification. On the other hand, while zymosis spoils the medium it operates on, the medium may be spoiled for the zymosis by the pathological development or by return to its normal physiological condition. Thus the old view that tuberculosis was due to a diseased state of the blood inducing a specific exudation, may be so far correct that unless some pathological change occurred in the nutrient media the tuberculous infection would not develop; it might be present indeed, or there might be exposure to it, but it would not act as a disease or cause of death unless as perpetuating and aggravating the prior condition itself, *per se* morbid, and, for all we know, capable of development on its own lines in the absence of the specific infection.

From the point of view, we may be justified in tentatively, at least, objecting to the position that the tuberculous infection is primarily itself a disease or cause of death, that it is so only as it interacts in a prior condition. We may conceive it as occurring in some animal system, including the human, as a normal event, not *per se* disturbing the normal state. This does not exclude the supposition that it may disturb certain organic systems on transmission from a system it does not disturb, since the nutrient media of the receptive system may be such as more easily gives the condition favouring development of the bacilli in number and virulence.

For the human system the question is whether the infection subsists, giving no pathological effects. We are so much in the habit of associating it with such effects that we never think of determining it as an initial occurrence not necessarily harmful in itself. If in any case it seems to be so, as, for instance, when transmitted from a healthy person, we pass the fact by. The logical conclusion would be for it, not as a rare exception, but as the general rule. If we proceed from this we will find that much of the obscurity enveloping the subject clears up. As our knowledge of the infection extends we get to see that our exposure to it is universal, and our experience of it almost equally so. Not only so, but the exposure is a common one for a large group of animals in contact with man, and the attempt to differentiate bacilli specific for each animal has utterly failed.

The response to the exposure, or the experience of the infection in man, is, of course, placed under limitation by the preconception that it is necessarily a disease; it is looked for only under the condition of some diseased manifestation or other. Even so, however, the manifestation, varying in degree from what is scarcely perceptible to rapid and fatal virulence, would justify the conclusion, or rather the judgment, conformable to our present knowledge, that the infection *per se* subsists essentially in a form consistent with normal organic integrity. It is of the utmost importance to take this view into consideration, since the presence of the infection in such form, while not disturbing normal integrity, may induce toleration of it, limiting thereby the mortality which, under some circumstances, it may cause. It is quite true that, in any case, the zymotic products of the tubercle bacillus affect the composition of the nutrient fluids, and thereby the life of the organic cell; but it is equally true that there is response or adjustment to the condition which, within certain limits, is only a case of the general physiological adjustment of the cell to the varying conditions to which it is normally subject. If for any reason the cell is unable to make the necessary adjustment, then the power for mischief of the tuberculous infection arises, but that adjustment can never be called into play in the absence of the occasion for it. The cell has normally the power of reacting to a host of circumstances, but the power, even though connate, in practice depends on experience of the circumstances. If the cell thus happens to have no experience of variation of temperature, its potential capacity of accommodating to the variation in the absence of experience of it does not save it when suddenly exposed to change of temperature.

As a potential cause of death, tuberculosis is to be judged by its typical form. Taking the form as invariably fatal, the restraint on the fatality is to be judged from the fact that infection invades the infant system in the first few months of life without causing any significant fatality. It does not in the least matter whether the proportion of infected infants is taken as 30, 50, or 100 per cent.; the evidence is wanting in any case of a fatality corresponding to the potential form. The extent of incidence of the infection is taken under the preconception of some morbid sign, or of the presence of the bacilli being necessary to determine it. The reaction to tuberculin is a more certain test, but, as far as I know, has not been sufficiently extensively applied to give experience of infection in infants in adequate numerical terms. That, however, does not matter so long as it is left undetermined whether the infection is permanent or not, whether, as occurring in a transient, imperfectly developed or speedily suppressed form, it does not prevent recurrence, or induce toleration or modification of itself in varying degree under recurrence. From personal observation of many hundred cases under the condition of non-discrimination between slight and severe, I venture to say that far and away the most prevalent form is recurrent, the recurrences being independent or distinct in the pure pathological sense. But, as I conceive, they are not independent in another sense; the experience under recurrence engenders as a sum effect and *cæteris paribus* toleration of the infection. The difficulty in the way of understanding this seems to me to arise from attention being concentrated on the severe permanent and progressive cases. It must, however, be allowed that these cases constitute in reality only a fractional part of the experience of the infection; they do not at all give us a general view of the experience. I am venturing again on expression of personal observation in saying that in a large proportion of the severe and fatal pulmonary cases factors apart from the mere tuberculous infection are more or less clearly in evidence. A statement which will receive so much corroboration from others hardly needs excuse. Another point will receive like corroboration. I have come across cases in which life was prolonged amazingly, although both lungs were riddled through and through with disease; not a square inch sound, and other cases rapidly succumbing although the greater part of both lungs were, apparently, at least, quite sound. The opinion that the difference was in proportion to induced tolerance may stand until we can form a better one.

A great many of our cases contradict the supposition that the system is poisoned by the infection or by the products of the bacilli and as many that death is caused by destruction or alteration of tissue. So far, however, as both causes exist and co-exist in some complex relation, it seems clear enough that the induction of toleration applies to govern the course of even the most severe cases. It would indeed be unnecessary to reason that experience of the infection induced tolerance of it, and that the induced tolerance was the chief restraint on an otherwise extremely fatal disease, if our formal doctrine and public opinion as based on it did not propose action directed to "stamp out" infection. The infection of small-pox was not stamped out; it, or a modification of it, was used to control itself in the light of the fact that it was so controlled.

My main position here is an expression for the infection at limit, to use a mathematical term. At an inferior limit the infection occurs in a transient and quickly-suppressed form, and that is only to give the series under which it occurs legitimate extension.

"Two calves "(" Second Interim Report of the Royal Commission on Human and Animal Tuberculosis," p. 9) "each received in the form of an emulsion the same estimated dose (9,000 bacilli) of the same emulsion of virus I. One calf died of general progressive tuberculosis, while the other, killed in apparent health, showed only a very limited retrogressive tuberculosis." The report goes on to make a more general statement to the same effect. Now, the latter calf would have reacted to tuberculin, but would it if the experience had been a transient one, leaving no effects, or effects completely recovered from? Or, taking the case of insusceptibility, the dose being supposed to be that ingested under ordinary exposure, are we to attribute it to something we do not know or something we do know—induced tolerance? The Commissioners say that they excluded prior spontaneous tuberculosis in the animals they experimented on as far as possible, but how could they exclude passing intestinal infection having no effect other than that of inducing tolerance? Or how could we in the case of children who, for all we know, are swallowing thousands of the bacilli and becoming accustomed to the thing as they would to mercury or opium, if constantly administered in harmless doses? The Commissioners speak of a "combat between the pathogenic energies of the bacilli and what has been called the resistance of the tissues." But the reaction we call resistance needs experience of the action resisted, and we are cognisant enough of the experience in general to know that, whatever other factors may enter its operation, it is not necessarily constant, but efficient through repetition.

Our line of inquiry, I conceive, should be directed to ascertain the extent of the tuberculous infection in the human subject as a normal and unavoidable occurrence. That it develops a formidable disease is quite compatible with the position that it is the most efficient agency in limiting the disease and the mortality from it. I have long ago come to the conclusion that tuberculosis in a transient form is almost universal among infants, often as an intestinal infection. But for some reason there is either connate or rapidly-induced tolerance of the infection in infancy; the mortality from it is out of all proportion less than it is in infected adults or adolescents. Nevertheless, as is stated in the report cited, "the same dose of the bacilli produces less effect on an adult animal than on a young calf. This result we may explain as due to the powers of resistance of the tissues increasing with age." The result, however, may be more easily explained by saying that tolerance acquired in infancy persists to enable the adult to resist the effects of the larger dose. But the tolerance is no doubt to be taken in relation to the "virulence" of the bacilli, a term expressing a variable distinct from dose. Induced tolerance, so far as it goes, protects the adult, but other factors arise both in the bacillus as an operating agent and in the individual it operates on. These factors, as prominent, obscure tolerance; we cannot, or do not, use that in treatment of the disease, and so incline to ignore it when it appears as a failure to us. Nevertheless, it may be, in reference to the potentiality of the disease and the mortality from it, the main agency averting a vast destruction of human life. What tuberculosis now does is as nothing as compared to what it would be capable of doing if under no restraint arising in itself.

While, of course, admitting that everything should be done for the individual patient, I have no faith in a "campaign" against tuberculosis resting on the notion of abolishing or diminishing the specific infection and exposure to it. Much, indeed, of what I see in print seems utterly absurd to me—fit to figure in mediæval medical lore. Treating the individual or protecting him against infection by any of the methods proposed is not a campaign against tuberculosis. We must learn, as in the case of small-pox, to use the infection itself before we can make any impression of a permanent nature on the mass incidence of the disease.

OPERATING THEATRES.

NORTH WEST LONDON HOSPITAL.

Two Cases of Chronic Abscess of Maxillary Antrum.—Mr. Mayo Collier operated with the most satisfactory results on two cases of abscess of the maxillary antrum of long standing. Now some six months have elapsed, and the two cases are entirely free from antral discharge, pain, or discomfort of any sort. The first case was one of a woman, æt. 48, who had had a discharge from the right antrum for the last eight years. She had to wash the cavity out daily with lysol lotion to prevent the discharge becoming offensive. An opening had been made in the site of the first molar tooth, and a drain was established here by a plug fitted to the false teeth. The case was apparently one due to an abscess at the root of one of the molar teeth bursting into the antrum and so infecting it. The tooth had been removed and the antrum washed out and drained by establishing an opening near the site of the first molar tooth. The patient now complained of the constant annoyance of having to wash out the cavity daily, and the offensive condition of its contents unless the cleansing was regularly performed. On the date of the first visit Mr. Collier washed out the cavity himself through the opening in the alveolus, and noted that the result showed flakes of green offensive pus and *débris*. He advised an immediate radical operation, and stated that no hope could be entertained of a cure or a restoration to the normal of the lining membrane by any further washing and disinfectants. The case was accordingly admitted, and Mr. Collier proceeded to operate by the following method. A long strip of flat sponge was packed in the inferior meatus of the nose from front to back with the double object of preventing blood passing into the pharynx, and also of preventing any damage to the septum when breaking through the inner wall of the antrum into the lower meatus. Mr. Collier pointed out that this was one of the most important steps of the whole operation, because it afforded not only a guide to the lower meatus but also a buffer to the impact of the chisel or drill that it was necessary to use in breaking through the inner wall of the antrum. A sponge was next packed in the buccal cavity so as to prevent any blood entering the pharynx. This was followed by a transverse incision at the junction of the lips and gum in the site of the canine fossa; the tissues down to the bone having being separated with an elevator and retracted up and down, the cavity was first found by introducing a protected gimlet. As soon as the cavity was made sure of, a cone-shaped burr was introduced in the site of the puncture, and the opening gradually enlarged until it was of sufficient size to admit the little finger of the left hand. By this means every nook and corner of the cavity could be carefully explored and the diseased tissue or polypoid granulations removed with a curette. Mr. Collier pointed out that it was not necessary to denude the interior of its periosteal covering; all that was necessary was to curette softly the whole lining membrane of its thickened and diseased covering. This being done the most important part of the whole procedure was undertaken, namely, that of making a large communication between the cavity of the antrum and the floor of the nose in the site of the lower meatus. If the outer wall of the nose, as it frequently is, he said, is thin, an elevator or chisel will pass easily through it from the floor of the antrum, but often the bone is of considerable thickness, and the gimlet has to be used at several spots before the elevator or forceps can pass easily. When a large opening had been established the sponge was withdrawn and the *débris* of bone and mucous membrane curetted and removed so as to establish perfect freedom from the nose to the antrum. The bleeding from the antrum and nose having been arrested by packing for a short time, the opening in the canine fossa was closed by stitching the periosteum and mucous membrane separately, and a pad was placed on the cheek so as to prevent displacement of the parts. The patient was removed to bed, and instructions were given that no washing or interference of any sort be adopted. Mr. Collier said this was a common-sense procedure suggested by the ordinary principles of surgery, and that no lesser operation could be expected to bring about resolution of the lining membrane of a cavity so peculiarly situated as that of the antrum.

The second case was that of a man, æt. 50, who had suffered from stinking discharge from the nose for several years before being treated. The fact of an abscess existing in the antrum was discovered by his local medical attendant, and a tooth having been removed the cavity was washed out in the usual way. This was not followed by resolution, and ordinary daily procedure had to be adopted to prevent the patient being offensive to himself and to others. Mr. Collier having ascertained by washing that the discharge was still persistent and offensive performed an almost identical operation as in the previous case with a similar most satisfactory result.

THERE are no fewer than 555 scarlet fever patients in the Birmingham city isolation hospitals. This is an increase of nineteen in the total recorded a week ago, when the aggregate was 536. Last week there were 71 fresh cases of the malady reported, as compared with 74 for the previous seven days. The type of the disease is not virulent, and consequently the case mortality is low, only two deaths attributable to the disease having been registered during the past fortnight. The general health of Birmingham is not bad, judged from the death rate, which last week was 15.5 per 1,000 of the population, the zymotic death rate being 1.2.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

MEETING HELD FRIDAY, NOVEMBER 8TH, 1907.

Sir THOMAS BARLOW, Bart., in the Chair.

Mr. J. HUTCHINSON, jun., showed a case of

TRIGEMINAL NEURALGIA.

in which the Gasserian ganglion had been excised for recurrence of the pain after intra-cranial neurotomy of the second and third divisions of the fifth nerve. The patient had had characteristic trigeminal neuralgia for seven years. Three years ago the inferior dental nerve had been resected through the ramus of the mandible. The pain had been relieved for a time, but 18 months later, on account of recurrence of pain, the second and third divisions had been cut within the skull. When the patient came under Mr. Hutchinson's care about a year later the pain had come back, and there was some return of sensation in the area of distribution of the second division. The Gasserian ganglion with the exception of the ophthalmic part was therefore removed. Mr. Hutchinson showed the case to demonstrate the comparative valuelessness of mere division of the nerves, whether within or without the skull. He referred to Abbey's operation of intra-cranial neurectomy with occlusion of the foramina with indiarubber.

Mr. CHARLES BALLANCE had several times done the operation of removal of the Gasserian ganglion with preservation of the ophthalmic part, and had found it satisfactory. He had recently had an opportunity of seeing Abbey's operation carried out by its originator. In some cases there had been a return of pain in five years, and at a second operation it had been found that a few filaments of the nerves had penetrated the foramina and restored the continuity of the trunks in spite of the rubber plugging. The great advantage of the operation was that it was extradural. Mr. Ballance had lately had to operate again upon a case in which four and a half years earlier he had done intra-cranial neurectomy and plugged the foramina with gold leaf. At the second operation it appeared that union of the nerves had occurred. In spite of such liability to recurrence he considered the operation compared favourably in many ways with the intra-dural methods.

Mr. HUTCHINSON replied.

Dr. BERTRAM ABRAHAMS showed a case of

MYOPATHY.

The patient was a man of 43; he gave no family history bearing on the case. There had been increasing weakness of the legs for 17 years and latterly of the arms also. There was wasting of the biceps, pectoralis major, quadriceps, gluteus maximus, and supraspinatus on both sides, and to a less extent of the pronators flexors of the left forearm, right hypothenar muscles and latissimus dorsi, together with the adductor and abductor muscles of the thighs. There was hypertrophy of the deltoids and serrati, and to a less extent of the triceps, infraspinatus and rectus abdominis. The deltoids did not respond to electric stimuli, but the reaction of all other muscles was normal. The erect posture was only maintained with much lordosis; the gait was markedly straddling. Dr. Abrahams said that the case seemed to be most nearly allied to Erb's juvenile form of muscular atrophy.

Dr. A. M. H. GRAY showed a woman of 41 with

TYPICAL SIGNS OF MYXŒDEMA.

who 16 years earlier had had exophthalmic goitre. When seen three years ago the patient had ascites which cleared up under treatment with thyroid extract. It occurred slightly when the treatment was temporarily discontinued. The thyroid gland could not be felt; a small papillary growth the size of a pea was present on the dorsum of the tongue just in front of the foramen cæcum. It was not thought to be of thyroidal nature.

Drs. Parkes Weber, Herringham, and Garrod discussed the case. Dr. Gray replied.

Mr. T. H. Openshaw showed a case of

RECURRENT DISLOCATION OF BOTH SHOULDERS CURED BY OPERATION.

The patient was a man of 27, an epileptic, and had had numerous dislocations of the shoulders during the fits. Many methods of treatment were tried without success. Finally the subscapularis was detached from its insertion into the humerus and united to a part of the deltoid. Mr. Openshaw had done this operation three times, in all cases with permanent success.

Mr. J. Hutchinson, jun., discussed the case.

Dr. Herringham showed a case of

NEURITIS OF THE BRACHIAL PLEXUS,

probably resulting from arthritis of the shoulder. Evidence of involvement of the whole plexus had followed within a few weeks upon an apparently rheumatic affection of the joint Dr. Herringham regarded the lesion as a perineuritis spreading to the nerve sheaths from the capsule of the joint.

Dr. Sidney Phillips referred to the frequency with which signs of joint affection are found in cases of neuritis.

Dr. Herringham also showed a case of "splenic anæmia," in which there was widespread pigmentation of the whole body.

Dr. Murray Leslie showed two cases of "congenital heart disease" in adults.

Dr. J. Fawcett read a short paper on the

TREATMENT OF PNEUMOTHORAX BY ASPIRATION UNDER THE X-RAYS.

He gave the history of a case in which the operation was done under the X-rays so that the necessary amount of suction could be exactly adjusted and no undue negative pressure be produced. The lung could be watched expanding as the air was withdrawn. He considered such treatment would in selected cases effect a considerable shortening in the course of the condition, and that it was therefore justifiable to incur the slight risk entailed.

Dr. Parkes Weber and Dr. Sutherland discussed the paper, and Dr. Fawcett replied.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held November 6th, 1907.

The President, Dr. Affleck, in the Chair.

Mr. Cotterill showed:—(1) Specimens from a case of panhysterectomy for fibroids and ovarian dermoids; (2) Pyosalpinx complicating appendicitis; (3) Spindle-celled sarcoma of foot; (4) Hydatids of liver; (5) Cerebellar tumour, successfully removed.

Mr. Cotterill also showed:—(1) A patient who, after being thrown from a gig, developed an orbital angioma, with marked proptosis of the right eye, and a pulsatory swelling giving rise to a bruit which could be heard both by the stethoscope of an observer and by the patient himself. In such cases ligature of the carotid had not always proved satisfactory on account of the very free anastomosis which took place. In the patient in question there was very considerable evidence of anastomosis, particularly with the nasal branches of the facial artery. He had, however, been encouraged by the fact that pressure on the common carotid checked the pulsation and bruit, and therefore the common carotid had been ligatured. The result was entirely satisfactory, the proptosis having disappeared, and the movements and aspect of the eye having become quite normal, except from some weakness of the sixth nerve. (2) A case of sarcoma of the chest wall. As in most cases of this kind, the growth of the tumour had been very irregular as regards its rapidity. It had begun in the posterior triangle of the neck, and was probably a lympho-sarcoma. The tumour was now very exclusive, and involved a large area of the chest wall. It was proposed to treat the case by Röntgen rays. In a previous case of similar nature very great improvement—indeed, almost complete disappearance of the sarcoma—had resulted from X-rays. On the interruption of the treatment, however, recurrence took place.

Mr. Alexis Thomson showed:—(1) A child with spontaneous fracture of the lower end of the femur, probably the result of osteomyelitis fibrosa. The fracture took place as the boy was standing in the street, without any violence having been employed. In spontaneous fractures of this kind union took place readily, but there was no means yet known of preventing recurrence. (2) A child with an unusual form of greenstick fracture of the forearm. The fracture was not, strictly speaking, greenstick at all, but a complete break of both bones. Union had not taken place, and there was extreme angular deformity. In fractures of both bones of the leg in children, it was sometimes extremely difficult to obtain union, and metal supports had to be used to prevent riding. He proposed to operate in this case, and unite ends of the broken bones. In the arm shortening was of little consequence; hence he would be able to remove the bone pretty freely, so as to get good union.

Dr. Robertson showed (for Mr. Stiles):—(1) A patient after extensive operation for epithelioma of the floor of the mouth. The tongue and the glands had been removed previously. (2) A patient, æt. 80, after operation for malignant disease of the upper jaw. In this case a preliminary laryngotomy had been performed. (3) A case of renal calculus in a patient who had suffered from Potts' disease of the spine.

The President delivered his valedictory address. After thanking the Society for the honour they did him in electing him to fill the presidential chair, he referred with gratification to the fact that during his term of office a large number of communications had been made by the younger members of the Society. This was as it should be, for the future of the Society depended on its younger members. In taking leave of the Society as its President, he wished to speak, however, not of the past, or of the future, but of the present, and to lay before them some results of the experience of more than

A GENERATION'S OBSERVATION OF DISEASE.

Dr. Affleck concluded his address, which was listened to with much appreciation, by expressing his wishes for the continued prosperity of the Society, and the security he felt that it would be in good hands, as he vacated the chair to allow Dr. Ritchie to ascend it.

(A full abstract of the President's address will be found on page 521.)

Dr. Allan Jamieson, in moving a hearty vote of thanks to Dr. Affleck for his conduct in the chair during the past two years, spoke in appropriate terms of the courtesy and tact with which he had guided the affairs of the Society, and the charming valedictory address he had delivered. Mr. Cotterill seconded the motion, which was carried by acclamation.

Mr. George Chiene then read a preliminary note on a

SIMPLE OPERATION FOR UNCOMPLICATED OBLIQUE INGUINAL HERNIA IN YOUNG ADULTS,

which will be found in another column, page 522.

The paper was discussed by Messrs. MacGillivray, Scott Carmichael, Dowden, Struthers, and Cotterill, and Mr. Chiene replied.

The following were elected office-bearers for the ensuing season:—President, Dr. James Ritchie; Vice-Presidents: Mr. C. W. MacGillivray, Dr. Byrom Bramwell, and Dr. Geo. Hunter; Council: Prof. Harvey Littlejohn, Dr. Aitchison Robertson, Dr. Keppie Paterson, Mr. W. Guy, Dr. Affleck, Mr. Berry, Dr. Gulland, Dr. Ker; Treasurer: Mr. J. W. Dowden; Secretaries: Mr. David Wallace, C.M.G., and Dr. F. D. Boyd, C.M.G. (editor of "Transactions"), and Dr. Wm. Craig.

Royal College of Surgeons, Ireland.

We are asked to announce that, on and after January 1st, 1910, all examinations for the Fellowship will be conducted under the scheme now known as Grade I. No candidate after the above date will, under any circumstance, be admitted to examination for the Fellowship of this College under the scheme now known as Grade II., which will then cease to be used.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, OCTOBER 25TH, 1907.

The President, A. R. PARSONS, M.D., in the Chair.

THE NITROGENOUS METABOLISM IN A CASE OF MYELOGENOUS LEUKÆMIA.

THE PRESIDENT read a paper on the above subject.

Dr. WALTER SMITH said it was not usual to discuss the Presidential Address, but he thought it would be unbecoming to pass over without remark a paper which marked a departure in the transactions of the section. It was a courageous attempt to investigate one of the darkest corners of pathology, the full investigation of which would tax the resources of the most skilled chemist. It was no disparagement of the paper to say that it did not lead to any definite conclusion. The same might be said of the general literature of the subject; and it might be safely asserted that up to the present chemical investigation failed to throw any light on the cause of leukæmia. The subject, moreover, was only part of the much larger subject of the general effect of diseases of the blood on metabolism, the metabolism generally taking the direction of catabolic destruction. Before they could get any general light on the subject, they must take into consideration other affections, such as gout with its uncertain relations to uric acid. More important than even the serious loss of proteins which had been observed in very acute cases of leukæmia, but not definitely in the chronic cases, was the question whether there was any distinction to be drawn, chemically or otherwise, between lymphatic and myelogenous leukæmia. There was, at any rate, one curious difference in regard to the nature of the cells that were found predominating in the two forms. Generally speaking, comparing the leucocytes with the large neutrophile cells, they were distinguished by a lesser chemical activity, and it would almost seem as if the chemical activity of the leucocytes in the normal body was held in check by anti-enzymes in the blood. They had become familiar with the doctrine that probably every cell in the body was, as it were, capable of eating itself. The chemical changes in the blood were so diverse that it was almost impossible to throw any light on the subject. All sorts of extraordinary things had been reported as existing in the blood. The xanthin bodies were well represented in the blood of leukæmia, but there were other bodies which might be *post-mortem* products. The solid exudate in acute pneumonia underwent resolution with puzzling rapidity; that was probably due to autolytic action, and we might probably look in that direction for the explanation of unresolved pneumonia. Dr. Parsons had been unable to trace any connection between uric acid and the leucocytes in leukæmia, and the fact that nitrogenous bodies in contact with the blood might furnish non-nitrogenous products showed how cautious they should be in interpreting the results of nitrogenous metabolism.

Dr. MAGEE FINNY said the subject opened up a great range for discussion. The practical point as to the X-rays being one of the great causes of improvement, if not the sole cause, was very important. It was not so long since the rays were only applied for diagnosis; cases in which they had been used as a means of therapeusis were not very numerous, and it seemed very remarkable that such results had been obtained in the case. A relationship between the elimination of uric acid and the white cells had been found; that, however, was valuable negative information for future observations.

Dr. PARSONS replied.

DR. TEED, the City of London analyst, in his recent quarterly report, mentions that the highest percentage of adulterated samples was in drugs bought with prescriptions. Out of seven prescriptions purchased, six were not made up in accordance with the demand of the purchaser, showing 85 per cent. of the prescriptions to be wrongfully compounded.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Nov. 10th, 1907.

PHLEGMASIA ALBA DOLENS.

IN spite of the progress of antisepsy and of obstetrical asepsy, which have diminished and almost removed puerperal complications, there is one exception, however, and that is phlegmasia. According to Boissard this affection is more common to-day than ten years ago, and is observed more frequently in private practice than in hospitals, where the women generally return to their homes before phlegmasia sets in.

Facts, parodoxical in appearance, would seem to prove, says Dr. Keim, that phlegmasia is not always due to puerperal infection. If on the one hand, it is observed in the course of convalescence of normal confinements, it is rare in certain cases of grave genital infection.

In the production of thrombosis, says Charrin, the presence of a germ is by no means indispensable. The blood can coagulate under the influence of the fibrin-ferment of the leucocytes in contact with the fibrinoplastic of the product. This coagulation, under the influence of chemical elements, can take place in two periods of puerperality; after delivery, under the influence of the chemical elements contained in the uterus itself; during the last weeks of pregnancy, under the influence of chemical elements of the neighbourhood and notably the intestine.

The increase of the coagulation of the blood during pregnancy, is due, outside the transformation of the liver, to the composition of the blood itself, which is rich in fibrin. This excess of fibrin persists a certain time after delivery; a favourable adjuvant in hæmorrhage, it can become an element of intravascular coagulation in retention of clots, exudation of serum and above all, after intra-uterine injection of salt water or corrosive sublimate. The blood of the uterine vessels is frequently put in contact, through the placental wound, with the products contained in the uterus; albuminoids, fibrinous clots, and for this reason phlegmation has been frequently observed following placenta prævia. Various are the conditions, consequently, outside infection, that would explain the frequency of abdominal venous coagulations and phlegmasia following delivery affecting either the uterus, the liver, or the blood, which do not exist after miscarriage.

The chemical causes have also their importance. They act by exaggerating the physiological thrombosis after delivery, and produce phlebitis of the uterus with subsequent extension to the lower limbs.

THYROID INSUFFICIENCY.

The slight symptomatic manifestations of thyroid insufficiency should be known to the medical practitioner in order for him to be able to apply the treatment of opotherapy. Dr. Henri de Rothschild has just published an interesting review on the stigmata of insufficiency of the thyroid gland.

Transitory Œdema.—Without any trace of albumin the affection is manifested by white, painless and elastic œdema, localised chiefly on the eyelids, the forehead, the malar region, and sometimes on the feet. This œdema returns more or less frequently, and is observed in the morning, after some annoyance, fatigue, migraine, or the menses. The repetition of these little signs have a certain diagnostic value.

Caloric Troubles.—These depend on the decrease of the thermogenic function of the thyroid body; but before assigning to them a symptomatic value the urine should be examined, for in cases of albuminuria they are also observed.

In any case they consist in a sensation of cold, particularly in the feet, but also over the whole body or in the back, the thighs, or in one or other of the extremities. The patient complains constantly of cold, and covers himself up in mantles or shawls and requires several bed coverings at night with the hot water bottle.

In these patients, the extremities are pale, the hands are cyanosed, and chilblains are frequent.

Other patients complain of shivers running through their whole body, especially the back, at certain moments in the day, generally towards four or five o'clock in the evening. They feel a sensation of iced water running down their back and limbs.

In a certain number of patients, the central temperature falls somewhat below the normal, particularly at night, and the slightest draught produces rheumatic or neuralgic pains, which we call lumbago, wryneck, migraine.

All these patients complain of fatigue in the morning; it is with reluctance they leave their bed and only recover their normal condition about half an hour after rising. They are also easily fatigued after walking some distance. This symptom is also found in neurasthenia.

Headache.—This symptom assumes two forms; frontal or occipital. Frontal headache resembles that of acute coryza, while in the occipital form the pain is over the seat of the occipital nerve, and resembles neuralgia. Generally more intense in the morning, it disappears in the evening or after a copious repast. In these patients are also observed muscular pains occupying different points of the body; the thighs, the intercostal muscles, those of the back of the neck, the lumbar region, etc.

Physical and Mental Insufficiency are frequently met with in these cases. A small number of internal secreting glands regulate the physical and intellectual development of a child, and in this the thyroid gland plays a capital rôle. Consequently a default in the function of the thyroid retards the growth and frequently the intelligence of the child. According to M. Hertoghe such children have difficulty in learning arithmetic and orthography, while stammering, incontinence of urine and cryptorchidia are freqeunt.

All of the above permanent signs of thyroid insufficiency are not necessarily to be found in the same individual, and one of them alone should not be considered as a basis for diagnosis, but where two or three are observed together they should attract attention.

GERMANY.

Berlin, Nov. 10th, 1907.

At the Society for Innere Medizin, Hr. E. Barth read an interesting paper on

The Physiology of the Tonsils and the Indications for their Removal.

He said that at present ideas as to the functions of the tonsils were not at all clear. Whilst one looked on them as indifferent structures, another considered them to be a protective apparatus against infection. From this want of clearness arose uncertainty as to the surgical treatment of the organs—for example, as to their removal in affections of the ear. As recent investigations had shown, the tonsils were composed of the same tissues histologically as the lymph glands, that they had therefore the same office in the organism; besides this, they had some macroscopical peculiarities that would be spoken of later. As regarded the function of lymph glands, the lymph was freed from foreign bodies such as micro-organisms, etc., in passing through them; they served, therefore, as a protective apparatus. Whether they possessed an internal secretion was still uncertain. The lymph glands further served for the production of lymphocytes. The tonsils would probably fulfil similar functions, the filtration of the lymph that poured through, and the production of lymphocytes. They had also the peculiarity of superficial position, and the formation of cells on their free surface. A stream of lymphocytes flowed through their epithelium, which formed a protection against the entrance of infectious germs into the interior of the tonsils. As it was assumed that the lymphocytes had no independent movement, it was believed that they were carried outwards by a stream of fluid. More recent researches, however, had shown that lymphocytes had an active independent movement; whether, however, any discharge of fluid took place was questionable. No epithelial openings through which the lymphocytes could pass were present on the surface of the tonsils. As pointed out above, the macroscopical structure was peculiar—an enlargement of the superficies by numerous lacunæ. Altogether, therefore, the tonsils, along with their character of lymph glands and the stream of lymphocytes, possessed a large surface and a strong secretion. The action of this structure and of these physiological properties of the tonsils was that of a mechanical protection against infection, and, moreover, chemical, fermentative, and antiseptic properties have been ascribed to them; but these had not been proved with certainty. The tonsils did not act phagocytarily. There was no evidence that the tonsils were the sites of blood formation.

Now as regarded the clinical properties of the blood in hypertrophy of the tonsils, we found an increase of the eosinophiles, a diminution of the neutrophile-polynucleated cells; but no specific influence on the formation of blood could be assumed at present. The tonsils were, however, by no means indifferent structures, as was assumed by many. They passed through a development dependent on age. In the youth of the individual they were in active function; in old age they underwent involution, as the protection they afforded was not so necessary as in early life. But the most dangerous general infections affected the tonsils. How was this to be brought into unison with the above views? The lymph glands were certainly protective organs, and yet they became flooded with infective material. It was further to be noted that the affections of the tonsils were often secondary. It had also been shown by experiment that foreign material escaped outwardly through the lymph glands. When micro-organisms were found in the tonsils, therefore, it must not be said they were the ports of entry for them, as they might have been carried there from the interior. Pathological changes in the tonsils did away with the protective function, and even caused them to act in a contrary manner.

Our therapeutic measures must be based on our knowledge of the functions of the tonsils. Healthy tonsils must, of course, be retained; those loaded with foreign detritus must be cleansed. In case of relapsing inflammations of the organs we must ascertain whether the inflammation was secondary; hypertrophy, even in itself, was no ground for removal of the tonsils, as, so long as they were composed of normal adenoid tissue, their protective power was increased. Tonsils should only be removed when the enlargement was accompanied by marked local disturbance, as upon the hearing. Children with enlarged tonsils were in greater danger in acute infective diseases, especially in scarlatina. Here the tonsils should be removed, and the removal should be done thoroughly. It was frequently done imperfectly, and a re-growth took place.

In removal it sometimes happened that the tonsils were so thoroughly taken away that firm cicatricial tissue formed to the detriment of the adjacent parts. The proper way to do this was to remove all above the level of the mucous membrane, so that that was retained intact.

AUSTRIA.

Vienna, Nov. 10th, 1907.

Glaucoma.

Chalupecky in his lectures maintains that traumatic glaucoma is a rare occurrence. The internal pressure of the bulb resulting from cicatrices of the cornea, occlusion of the pupil, luxation of lens, etc., are temporary conditions following an accident that frequently occur and can immediately be relieved. Glaucoma is a more serious affair, and might arise as a secondary disease.

We cannot refuse to accept that some cases of traumatic glaucoma sometimes appear, and among these the older authors supply us with a few published cases. Graefe expresses himself in similar terms, and closes by saying that you will hardly ever meet with traumatic glaucoma in a healthy eye, but as a secondary result you may.

Landesberg records one case of considerable interest in this respect. A young officer, æt. 46, was engaged in the war of 1866 when suddenly a bullet whizzed past his left eye without actually wounding it, but he became instantly blind with it while he continued to shoot with his right till he got his left leg smashed and had to be taken to hospital, where Graefe confirmed the glaucoma. This is a case that must be received with caution. It is possible that this eye was glaucomatous before he entered the battlefield, and as he shot with the right eye it is very probable that no notice was taken of the glaucoma till the accident.

At a later date, 1881, Ferber relates how a boiler-maker had his left eye injured with a splinter of iron and was blinded. In 1887 a similar accident happened to his right eye, which hitherto had been considered sound. On examination four weeks after the accident vision of left eye = able to count fingers at a metre distant; right eye, able to count at 1½ metre distance; tension, one degree harder, iris striated, opacity, retina covered with a white exudation in which was extravasated blood, and excavation of the papilla. Iridectomy was performed with resulting bleeding from the yellow patches. After nine weeks residence he was dismissed with vision = $^{3}/_{6}$ The glaucoma in this case is attributed to a traumatic irritation of the secreting ocular nerve producing a neuropathic hypersecretion with final intra-ocular pressure.

More recently Praun recorded one from Fuch's clinic of a boy who got the eye injured with a piece of iron, producing ciliary injection, opacity of the vitreous humours, hyperæmia of papilla, and veins, while the arteries were observed to pulsate; the outer half of the retina became detached and the tension was increased. Pilocarpin was administered and the retina subsided, but rose again after a short cessation worse than ever. The glaucomatous process increased, iridectomy simply relieving tension. This may be considered a veritable case of traumatic glaucoma complicated with separation of the retina, probably due to the irritation of the tensor and intra ocular pressure.

Garnier relates the case of another boy, æt. 11, who got a stroke on the eye followed by intra-ocular tension, and within ten days the eye became so staphylomatous that it had to be enucleated. The vessels were found in a hydræmic and swollen, or dilated, condition. The cause in this case seemed to be a blocking of the lymphatic vessels.

Sala endeavours to explain the cause of glaucoma by telling how he commenced to operate on an eight year child for a soft cataract, and when he had pierced the cornea no fluid came out, but the tension was instantly relieved. His inference is that the lens swelled and the corneal-iris angle became mechanically closed. The thick colloid mass that forms in the anterior chamber of the eye is an important factor in the production of glaucoma. Sometimes, however, the serous iris is the cause of the tension, although it is attributed to an increased secretion of fluid, but the real cause is more probably the albuminous colloid substance. In slight cases of glaucoma warm compresses, massage, and puncturing the anterior chamber will increase the circulation and relieve the stoppage in the corneo-iris angle, and thus avert a calamity. Intra-ocular tension after contusion is relieved in a similar manner. Experiments with eyes prove that albuminous fluids do not pass easily along the Schlemm canal; thus a quantity of albuminous fluid in the anterior chamber produces first a congested state of the fluids of the eye, compressing the vessels and producing hæmatic stasis, followed by closure of the corneo-iris angle and increased tensor that results in glaucoma.

Tuberculosis.

At the conference Panwitz discussed the cost of public sanatoria in the struggle with tubercle. A good sanatoria should be erected for £200 per bed.

Rumpf thought sanatoria were like "Kirks" or schools, and should be built substantially without consideration of cost.

Tausig was of opinion that they should be put up with the greatest economy, as public bodies were far too extravagant. Teleky agreed with the latter, as the sanatoria were only for the overflow of the existing institutions.

The result of the discussion on the methods of infection were that none can define one channel through which it passes at the exclusion of others—lungs, bowel, or skin are difficult to determine.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Suspected Case of Plague in Glasgow.—A suspected case of plague has occurred in the South Side of Glasgow, a district in which there is a considerable foreign population, and in which a limited outbreak of the disease occurred in 1900. The patient was at once removed to hospital, and as nearly a fortnight has elapsed since his isolation without the occurrence of any fresh cases, there seems no reason to fear that the experience of seven years ago will recur.

Rowdiness at the Glasgow University Graduation.—The ordinary degrees in Medicine and Law were conferred at the Graduation ceremonial held in the Bute Hall on November 7th. There was a crowded attendance, and rowdiness on the part of the students was a conspicuous feature of the proceedings, benches being torn up to make an arena for a private feud between the engineering and medical undergraduates, which was waged, however, without the knowledge of most of the audience, so great was the din of whistles and singing made by the other students present. The Principal made the usual appeal for silence prior to offering a Latin prayer, but the appeal, like the prayer itself, and the subsequent proceedings, was quite unheard. The whole of the ceremony, which lasted for half an hour, practically proceeded in dumb show, the graduates coming forward, being capped, and returning to their seats, the only evidence of their identity being that obtainable from the printed lists. Fortunately there were neither honorary graduates—who might have felt that they were being treated with discourtesy—nor orators, whose feelings required to be considered; in fact, a purely domestic row.

Edinburgh Royal Infirmary.—At their meeting on November 4th, the managers appointed Dr. Edwin Bramwell, F.R.C.P.Ed. and Lond., to be an Assistant Physician to the Royal Infirmary.

BELFAST.

Ulster Medical Society.—The opening meeting of the session was held in the Medical Institute on Thursday evening, November 7th, when the President, Dr. John McCaw, delivered an important and interesting address on "Tuberculosis in Childhood and its relation to Milk," which will be published at a later date. Dr. McCaw's long experience as physician at the Belfast Hospital for Sick Children, and his special attention to the diseases of childhood qualify him to deal with this subject, and though much has been said and written on tuberculosis of late, he succeeded in being fresh and interesting, as well as practical.

Public Health and the Registration of Deaths.—At the last meeting of the Public Health Committee a letter was read from the Chief Secretary for Ireland, in answer to a request that he should receive a deputation on the above subject. He points out that he is aware that no arrangements exist by which particulars of deaths occurring in the city are communicated to the sanitary authority, and that while he recognises the importance of such an arrangement, there is no way at present of bringing it into existence. He proposes, therefore, to consider whether it will not be possible to introduce legislation next session to apply Section 28 of the Registration of Births and Deaths Act, 1874, to Ireland. The section referred to requires every registrar to furnish a sanitary authority, when required by such authority, particulars of any deaths registered by him, on forms supplied by the sanitary authority, who shall pay twopence for such return, and a further sum of twopence for every death entered in the return.

LETTERS TO THE EDITOR.

THE CANCER PROBLEM.

To the Editor of The Medical Press and Circular.

Sir,—Among the various theories advanced as the cause of cancer, excess of nitrogenous diet seems to be a likely one, while others suppose that the meat from an unhealthy animal is a more probable cause. I have a strong suspicion myself that the large consumption of frozen meat, either supplied from abroad or killed here and kept in cold storage, should be just as likely a cause of cancer, if not more so. I have been informed by those who know that carcases of sheep are sometimes kept in a frozen condition for three years before being sent to the various retail shops. Could such meat be healthy to consume, even supposing (which requires a stretch of the imagination) that such carcases were those of healthy animals? The cold storage system I detest, as neither vendor nor purchaser can tell *when the animal was killed*. It would be interesting in this connection if reliable statistics could be obtained of the percentage of cancer cases in the United Kingdom before and subsequent to the introduction of this vile method of retarding decomposition by means of cold storage.

I am, Sir, yours truly,
Alexander Duke.

REVIEWS OF BOOKS.

BLOOD STAINS: THEIR DETECTION AND DETERMINATION (*a*).

The differentiation of blood stains from other stains, and the determination of the source of stains proved to be blood, is one that presents oftentimes very great difficulties—even to the skilled expert. To help the expert to come to a conclusion, a large number of tests—chemical, spectroscopic, serological, biological, and microscopical—have been devised. Some of these tests are satisfactory up to a certain point, and then fail; others are fallacious; while one or two have for years stood the closest investigation without our confidence in them being in any way lessened. In the case of all of them, however, certain details of technique must be followed, and some of our text-books on forensic medicine admittedly do not give sufficient details to allow the investigator to make the most of the tests at his disposal. For these reasons a book devoted entirely to the subject, in which no essential detail is omitted to make room for other matter, and in which practically the whole of the various tests are considered as to their faults and limitations, cannot but be of the highest service to the medico-legal expert. A bibliography containing some 336 references to the tests shows the enormous amount of work that Major Sutherland has devoted to the compilation of this volume, and his personal wide experience, his perspicacity, and his thorough and conscientious study have enabled him to produce a thoroughly trustworthy work, which we can with all confidence recommend to the coroner, the general practitioner, and to the worker in the clinical laboratory.

ANTISEPTIC METHODS (*b*).

"Antiseptic Methods" lays down certain guiding rules for the application of the general principle with which it is concerned. But the title does not suitably describe the scope of this little work, as it almost entirely deals with what we usually understand the "Aseptic" technique in operation, and during the dressing of surgical wounds.

The author, Mr. Upcott, draws attention to many apparently trivial but really essential details, which it is necessary to bear in mind to prevent wound infection. For instance, the precaution which should be taken in the preparation of the patient, the handling of sutures and basins during operations, and the subsequent removal of the stitches, are considered.

"Antiseptic methods" is written for dressers and surgical nurses. The beginner will certainly find it a very useful little book.

INTUSSUSCEPTION (*a*).

In this little book, the author, Mr. Clubbe, relates his experiences, which extend over a period of thirteen years, in the treatment of Intussusception. During this time he has dealt with what appears a very large number of cases (144).

The author is a strong advocate of a preliminary irrigation. He says: "I think injections of warm oil should be given in all cases, after the child is under the anæsthetic, even in cases of long standing, when we know that it is impossible to complete the reduction by these means. My reasons are these. It always reduces the intussusception to a certain extent, and in the best and gentlest possible way; in this way it lessens the shock of the coming operation, because less manipulation of the intestines is needed. It is specially useful in cases in which we find the intussusception in the rectum, because if we do not use it we may find some difficulty in getting our fingers below the tumour to commence the squeezing process." In fourteen cases reduction was brought about by this method alone. From his observations in 124 laparotomies for this condition the author asserts positively that adhesions between the invaginated portion of the gut do not exist, even when resection of the intestine is necessary. The irreducibility is due to the swelling and thickening of the intussusceptum.

This book is well worth perusal, especially by the young practitioner. Mr. Clubbe's style is simple and graphic, and he draws a very vivid picture of the symptoms of Intussusception, but his account of the differential diagnosis is scanty.

TRANSACTIONS OF THE ROYAL ACADEMY OF MEDICINE (*a*).

In this volume the first section, that of medicine, is the largest, and contains several papers of great interest. It opens with a paper in which the author explains the commonest functional heart murmur—*i.e.*, pulmonary systolic murmur—as being due to dilatation of the infundibulum of the right ventricle.

A long paper, entitled "Our Debt to Ireland in the Study of the Circulation," follows. In this is shown the enormous amount of work contributed to this branch of medicine by Irish physicians from the time of Graves and Stokes to the present day. Next are several papers which formed the subject-matter of a debate on the treatment of gastric ulcer. Of these, two are contributed by physicians, and two by surgeons. There is a paper, with bibliography, on the rare condition of movable spleen, founded on a case which simulated a movable kidney, with intermittent hydro or pyo-nephrosis. Another paper of interest is one on a case of myelogenous leuchæmia, in which the white blood corpuscles were reduced after three and a half months' treatment by X-rays from over 900,000 to 10,000, with reduction of a greatly enlarged spleen to normal size, and a corresponding improvement in the general symptoms.

In the surgical section the contribution on "Sphincteric Control of the Male Bladder and its Relation to Prostatectomy," will attract attention. The author comes to the conclusion, after performing various experiments on dogs, that probably in man the internal sphincter vesicæ is the important muscle, and not the compressor urethræ, as generally supposed. The idea

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(*a*) "Blood Stains: Their Detection, and the Determination of their Source." A Manual for the Medical and Legal Professions. By Major W. D. Sutherland, of His Majesty's Indian Medical Service. Pp. 167 and xiii. With eight illustrations and two plates of spectra. 1907. London: Bailliere, Tindall and Cox. Price 10s. 6d. net.

(*b*) "Antiseptic Methods; for Surgical Nurses and Dressers." By Harold Upcott, F.R.C.S. Pp. viii and 51. London: Bailliere, Tindall and Cox, 1907.

(*a*) "The Diagnosis and Treatment of Intussusception." By Charles P. B. Clubbe, Hon. Surgeon to the Prince Alfred Hospital, Sydney; Joint Lecturer in Clinical Surgery at the Sydney University. Pp. x and 92. Edinburgh and London: Young J. Pentland. 1907.

(*b*) "Transactions of the Royal Academy of Medicine in Ireland Vol. xxv. Dublin: John Falconer. 1907.

of these experiments was originated by a case under the author's care, in which, after perineal prostatectomy, the patient had voluntary control over micturition, which took place through a fistula in the perineum.

"Limits of Abdominal Operations" is the title of a paper concerning movable kidney, vermiform appendix, and gastroptosis. With most of what is said we are in accord, but we find it hard to reconcile the following two statements:—"I venture to think that one attack of appendicitis is sufficient to justify operation," and "I do not think operation advisable during a first attack, nor, indeed, during any attack, unless there is present some special indication." Surely it is better to remove the appendix at once, provided, of course, the case is seen sufficiently early—say, within the first 24 hours.

Then follow papers on a comparison of the treatment of enlarged prostate witnessed in some of the hospitals of Paris, Berlin, and London; on chronic pancreatitis successfully treated by draining the gall-bladder; on fractures of the shaft of the femur, advocating treatment by a modified Park Hill apparatus. The last paper in this section is one on intestinal obstruction, based on a series of 12 cases. In this the author speaks very strongly on the subject of high mortality—at least 40 per cent., "which disgraceful state of affairs," he says, "must be largely attributed to the pernicious habit of meddlesome medication and delay until the unfortunate patient is so profoundly poisoned by toxic absorption from his intestine, and exhausted to such an extent by pain and vomiting, that he is quite incapable of withstanding even the simplest surgical procedure." We fully endorse this statement.

This section concludes with brief abstracts of numerous cases and specimens shown at the meetings. We are glad to note that several of the contributions in this volume are by physicians not resident in Dublin, showing that the Society is not merely of local interest. Then follow the sections of obstetrics, pathology, State medicine, anatomy, and physiology.

DISEASE IN CHILDREN. (*a*)

No one who is acquainted with Dr. Sutherland's skill as a diagnostician and teacher can fail to open this book with eager expectancy. We look for thoroughness in anything that he puts his name to, and in this case we are not disappointed. This is certainly one of the best of the Oxford medical publications. It is written in a somewhat authoritative style, but there is throughout much that is convincing. We are pleased to observe that the author does not recommend arsenic in the treatment of chorea. With small doses he has never got good results, while large doses, he says truly, are not by any means free from risk.

In connection with congenital pyloric stenosis we observe that the author still ventures to recommend operation, especially in those cases where medical treatment has failed. In this respect he follows the teaching of most authorities at the present time. He has a good deal to say on the subject of incontinence of urine, and he mentions adenoids and enlarged tonsils as associated causal conditions. This, however, is not our experience, and we have frequently found the condition actually rendered worse by operation for these growths. He prefers atropine to belladonna, as the former is more active. This is Holt's teaching, and we believe it is to be highly commended. To be of any value, however, it must be given in full doses.

Vulvo-vaginitis in its commonest form, he says, is due to want of cleanliness. In other words it is simple and not gonorrhoeal in nature. We are glad to find that this is the opinion of a practical observer as Dr. Sutherland undoubtedly is, for we so often hear it taught in these days that the majority of these cases in children are really due to the gonococcus. In fact, it will be found that the author's teaching is uniformly sound and common-sense in principle. The book is free from padding and unnecessary verbiage. All the commoner diseases of infancy and childhood are included. An appendix of useful prescriptions completes this thoroughly practical little work. We heartily recommend it as a guide to junior practitioners and to those who for some reason or other have not made a special study of children's diseases during their medical curriculum. A study of this volume will afford the reader many valuable hints which he will find of very great service in practice.

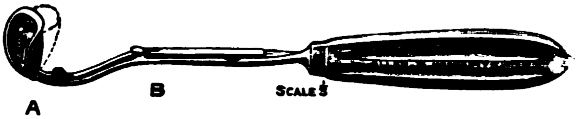
THE MODERN TREATMENT OF PULMONARY CONSUMPTION (*a*).

DR. LATHAM'S book has now become one of the standard works on the subject with which it treats, and it is so well known that a brief notice is all that is necessary of the third edition. The most important change in the present edition is the insertion of a section on the value of the opsonic index in diagnosis and treatment, and the use of the new tuberculin. It will, we are sure, be a great satisfaction to many clinicians to learn from Dr. Latham that in his experience the treatment by tuberculin can be quite as readily carried out and as safely controlled by clinical evidence as by the opsonic investigation. Were we dependent on the opsonic investigation for the use of tuberculin, its use would be very much limited—among the poor, at all events, where it is most wanted. We sincerely trust that the book will have a wide circulation among the general practitioners of this country, where all forms of tuberculosis are so common.

NEW MEDICAL AND SURGICAL APPLIANCES.

A NEW POST-NASAL CURETTE.

THE use of a curette for the removal of adenoids, in preference to the post-nasal forceps, has now become an established method. It was Delstanche who first invented an ingenious hinged and toothed cage to Gottstein's curette. The post-nasal curette generally used has a straight shaft from the catch to the handle, and when introduced behind the soft palate and swept downwards and backwards, the shaft of necessity is elevated, the result being that considerable bruising of the uvula and soft palate is caused. In the instrument devised by Mr. William Lloyd, F.R.C.S., and manufactured by Messrs. Allen and Hanburys, Ltd., the shank is curved from A to B, with the result that in the large number of cases in which the inventor has used it, traumatic inflammation, etc., is avoided.



NEW "TABLOID" SLIPPERY ELM.

MUCILAGE of slippery elm is largely used as a demulcent and astringent sedative. Alone, or combined with phenol, it is employed locally in pharyngitis and other throat affections, and internally in diarrhoea and dysentery. The mucilage is also stated to have a nutritive value. In tabloid form slippery elm presents a convenient means of administration. Each represents 5 gr. (0.324 gm.) of the mucilage, and one may be slowly dissolved in the mouth or swallowed whole with water as required.

CARBOLIC ACID AND SLIPPERY ELM.

Each tabloid contains carbolic acid ½ gr. (0.032 gm.). One may be slowly dissolved in the mouth, or one to two swallowed whole with water twice or thrice daily after food. Both the foregoing tabloids are issued in bottles by Messrs. Burroughs, Wellcome and Co.

(a) The Treatment of Disease in Children." By G. A. Sutherland, M.D., F.R.C.P., Physician to Paddington Green Children's Hospital, etc. London: Henry Frowde, Oxford University Press. 1907. Price 5s. net.

(a) "The Diagnosis and Modern Treatment of Pulmonary Consumption, with special reference to the Early Recognition and Permanent Arrest of the Disease." By Arthur Latham, M.D. Third Edition. 8vo. Pp. iii and 257. London: Bailliere, Tindall and Cox. 1907. Price 5s. net.

MEDICAL NEWS IN BRIEF

Death Under Nitrous-Oxide Gas.

MR. WALTER SCHROEDER held an inquest at Holborn on November 9th on Louisa Allen, 30, who died at a dentist's.

The husband, Alexander Allen, said his wife had suffered from neuralgia for some time, and had been under medical treatment for the last three months. She went to the Welbeck Street Dispensary for Epilepsy and Paralysis, and she was advised to consult Mr. Cox-Moore regarding her teeth. She went to him, and he extracted four of her teeth. She left home on Thursday seemingly in good spirits, in order to go and have more teeth taken out. Later in the day witness was summoned by telegram, and on arriving at the dentist's he found that his wife had died under the operation.

Mr. Edward Cox-Moore said he had practised as a dental surgeon for twenty-five years. Mrs. Allen went to him as a Hospital Saturday Fund patient, and had four teeth extracted under a nitrous-oxide gas anæsthetic. When she came on the second occasion he administered a moderate dose of gas nitrous-oxide, using a face apparatus which was regarded as perfectly safe. The gas took effect, and he took out the teeth that had been selected, and found the woman in a normal state and regaining consciousness. About two minutes later she lurched forward and died. He believed that the patient was not under the influence of the anæsthetic when she died, although he would not positively state that she had recovered consciousness. He had for the last seven or eight years given an anæsthetic to about 1,500 persons annually, without mishap.

Witness's statement was corroborated by John L. Burden, who assisted him.

The evidence of Dr. W. Harper, Bloomsbury Square, was to the effect that death was due to syncope whilst suffering from fatty degeneration of the heart and whilst under the influence of an anæsthetic.

A verdict of "Death from misadventure" was returned.

Spreading Scarlet Fever.

WILLIAM RANCE, a fried fish dealer, of Leyton, was summoned at Stratford for exposing a child while suffering from scarlet fever without proper precautions.

Dr. F. J. Taylor, Medical Officer of Health for Leyton, prosecuted, and said that on October 16th he examined defendant's child, certified it to be suffering from scarlet fever, and gave directions for isolation. On the 17th Mr. Miller, sanitary inspector, found the child isolated, but on the 23rd the boy was seen running about with other children. The defendant said the child was a great trouble, and he had no control over him. On October 25th, when the inspector called, the boy was seen without a coat and with wet hands. He said he had been washing potatoes. On October 29 the boy's mother said he was out of doors—she could not keep him in—but the next day isolation had again been resorted to. On the 31st Mr. Miller saw the boy in High Road, Leyton, wheeling his sister in a cart.

Dr. Taylor added that there was a great deal of scarlet fever about, and the ignorance of people created a difficulty, but when persistent obstinacy was added to it there was more difficulty still.

The defendant said at first he did not know the child was suffering from scarlet fever, and when he was told his wife did her best to keep him upstairs, but he would not stay.

The Bench said they regarded it as a serious matter, and imposed a fine of 20s. and costs.

Dublin Hospital Sunday Fund.

THE annual collection for the Dublin Hospital Sunday Fund took place on Sunday last, and will, we trust, result in a large addition to this most valued fund. The fund assists no fewer than 15 institutions, which provide 1,543 beds for the sick poor, and receive annually 16,000 patients, in addition to the many treated at outlying dispensaries, and about 29,000 accident cases. Since 1897 the fund has distributed to the hospitals no less than £126,775 15s. 9d. During the past two or three years the collections have been smaller in comparison with previous years. The Earl of Meath, President of the fund, has made an appeal in its behalf which we hope will re-establish the fund on its old basis, and thus further a most necessary work. Additional contributions may also be sent to the Royal Bank of Ireland, Dublin, or to the Treasurer, Mr. Joseph T. Pim, of 22, William Street, Dublin.

Session of the General Medical Council.

WE are requested to announce that the autumn meeting of the General Council of Medical Education and Registration will commence on Tuesday, the 26th inst. The President, Dr. Donald MacAlister, will take the chair at 2 p.m.

PASS LISTS.

Conjoint Examinations in Ireland.

THE following candidates have passed the First Professional Examination of the Royal College of Physicians and the Royal College of Surgeons:—

U. L. Bourke, F. E. Fitzmaurice, J. M. Gilmore, C. W. Joynt, J. Kirker, C. J. Kelly, A. G. J. MacIlwaine, B. Malaher, B. Murphy, D. McDevitt, B. Neary, A. J. Neilan, J. M. K. O'Byrne, J. H. Rishworth, C. Roche, G. Wilson, G. Young.

The following have passed the Second Professional Examination:—J. J. Barry, F. J. Graham, P. Grace, R. H. Hodges, W. H. Murray, M. O'Brien, H. C. Smyth, J. P. Shorten.

The following have passed the Third Professional Examination:—S. J. Barry, A. J. Bennett, G. E. Beggs, H. F. Blood, T. C. Casey, Miss C. Daniell, J. C. L. Day, E. C. Deane, E. Dundon, H. Hunt, F. M. Harvey, S. W. Hudson, L. C. Johnston, J. O'L. Murray, J. Menton, M. C. O'Hara, J. C. O'Connell, R. Power, W. F. Russell, C. D. K. Seaver, I. Scher, H. B. Sherlock.

The following have passed the Final Examination:—C. W. Green (Honours), M. D. Healy, M.D., Denver Univ. (Honours), J. McNamara (Honours), H. C. Carden, W. J. Connolly, A. Curry, B. Foley, G. A. Francis, E. H. F. Gilligan, G. J. M. Martin, E. Montgomery, W. St. L. Moorhead, P. J. Murray, C. McQueen, M. H. O'Sullivan, J. T. Rearden, G. F. Shepherd, P. D. Walsh.

The following candidates have passed the Diploma in Public Health, November, 1907: Major J. W. Bullen, M.D., R.U.I., R.A.M.C.; E. J. Day, M.D., Univ. Durham; F. C. Drew, M.B., Univ. Edin.; Capt. D. P. Johnstone, L.R.C.P. and S. Edin.; G. A. Moorhead, F.R.C.S.I.

Apothecaries' Hall of Ireland.

AT examinations recently held, the following candidates passed in the subjects indicated:—John W. Harvey, Physics; J. Stewart, Physiology; John Clarke and J. Hargraves Robinson, Pathology; Alexander Silbermaine and John Clarke, Hygiene; Major Moody, Alexander Silbermaine, and John Clarke, Medical Jurisprudence; Alexander Silbermaine, Materia Medica (Honours); John Clarke and Alexander Silbermaine, Pharmacy; J. M. Downer, Khaja Moinuddin, and N. Murphy, Surgery; S. V. O'Connor and J. Hargraves Robinson, Medicine; J. M. Downer and J. Hargraves Robinson, Midwifery (Honours).

The Diploma of the Apothecaries' Hall was granted to the following candidates, entitling them to practice Medicine, Surgery, Midwifery, and Pharmacy: J. M. Downer, Khaja Moinuddin, and N. Murphy.

Faculty of Physicians and Surgeons of Glasgow.

AT a meeting of the Fellows of the Faculty last week, the following office-bearers were appointed for the following year, viz.:—Dr. John Glaister, President; Mr. D. N. Knox, Visitor. Councillors: The President, ex-officio; The Visitor, ex-officio; The Treasurer, ex-officio; Dr. J. Lindsay Steven, as Representative to the General Medical Council; Dr. Robert Perry, Dr. Neil Carmichael, Mr. H. E. Clark, Dr. Ebenezer Duncan, Mr. J. Walker Downie, Dr. John Barlow; Dr. W. G. Dun, Treasurer; Dr. J. Lindsay Steven, Honorary Librarian. Board of Examiners for the License: William H. Hill, LL.D., Clerk; Alexander Duncan, B.A., LL.D., Secretary and Librarian; Walter Hurst, Assistant Secretary and Librarian; William Matthews, Officer.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Recurrence of Retroperitoneal Lipoma.—Johnstone (*Brit. Med. Journ.*, Oct. 12th, 1907) reports a case in which he removed a retroperitoneal lipoma weighing 21 lbs. in 1905. It was situated in intimate relation to the right kidney and ureter, and the tumour was shelled out of its bed apparently completely. The patient remained perfectly free from disease for about two years, but then commenced to suffer from stomach troubles. On re-admission to hospital the abdomen was found to be distended and filled with lobulated tumours. The individual masses were firm in consistence, and one in particular was so hard that malignant recurrence was feared. On opening the abdomen the tumour was found to consist of a number of lobules varying in size from that of a goose egg up to that of a Rugby football. They were more or less pedunculated, and only united at their common site of origin, which was in the right flank in angle between the outer border of the kidney and the iliac crest. All the masses were removed, the perirenal fat being completely cleared away, leaving the quadratus lumborum bare. The peritoneum was sutured over the denuded muscles, and the abdomen closed. The tumour masses weighed altogether 12½ lbs., were pinkish white in colour when fresh, and the microscope showed typical lipomatous tissue, with no trace of malignancy. The patient had an uneventful convalescence. S.

Anastomosis Between the Common Bile Duct and the Duodenum for Obstructive Jaundice.—Fullerton (*Brit. Med. Journ.*, Oct. 26th, 1907) reports the following case:—The patient, a male, æt. 66, had no history of any illness whatever since childhood. He was quite well until three weeks before admission into hospital, when the patient's friends noticed that he was jaundiced, and he commenced then to lose flesh. There was no pain. The liver was enlarged, and the gall-bladder was distended almost to the umbilicus. The probable cause of the condition was thought to be carcinoma of the head of the pancreas or of the common bile duct near its termination. No tumour except the distended gall-bladder could be felt. On opening the abdomen the gall-bladder was found to be larger than a goose's egg, and contained three small stones. None were found in the cystic duct. When the liver was drawn up, a hugely dilated common bile duct, about as large as a piece of small intestine, was found. On opening the duct a quantity of glairy fluid with no trace of bile in it escaped. The finger could be introduced into the duct and passed up into the cavities in the liver, corresponding with the hepatic ducts. With some difficulty the common bile duct was anastomosed to the first part of the duodenum with a Murphy's button. The gall-bladder was stitched to the peritoneum and transversalis fascia, and drained. Three weeks after the operation the Murphy's button was passed, and about the same time the gall-bladder fistula closed. On examination five months after the operation the patient was found to be in good health and had put on flesh. S.

Cholecystectomy: The Indications and Contra-Indications for its Performance.—Mayo Robson (*Brit. Med. Journ.*, Oct. 26th, 1907) is strongly of the opinion that the gall-bladder should not be treated as a dangerous organ in the summary fashion in which we now deal with the appendix. The gall-bladder adds mucous to the bile, and thus makes the latter less irritant. If the reservoir function of the gall-bladder is lost, it leads to dilatation of the common bile ducts and the hepatic ducts and back pressure on the secreting part of the liver. Mayo Robson has also found that at times this condition leads to interstitial pancreatitis. The author has removed the gall-bladder 94 times in nearly 1,000 operations on the biliary passages. The indications for cholecystectomy are:—(1) In cancer or other new growth of the gall-bladder. (2) In contracted and useless gall-bladder, the result of repeated attacks of cholecystitis. (3) In dilated and hypertrophied gall-bladder resulting from obstruction of the cystic duct. (4) In phlegmonous or gangrenous cholecystitis. (5) In empyema of the gall-bladder. (6) In mucous fistula of the gall-bladder, the result of stricture or other obstruction of the cystic duct. (7) In gunshot or other serious injuries of the gall-bladder or cystic duct. Cholecystectomy is contra-indicated in all cases where the surgeon cannot be certain that the deeper bile passages are free from obstruction unless at the same time the cystic or common bile duct be short-circuited into the intestine. S.

Rupture of the Liver: Operation—Death.—Haubold (*Med. Record*, Oct. 26th, 1907) describes the case of a man, æt. 29, who fell about eight feet and struck the lower portion of the right chest against a pile of lumber. This caused him considerable pain, but he walked a long distance home without any assistance. During the night he vomited the contents of the stomach, and the pain in the side increased. On admission to the hospital next morning a linear contusion was found extending from the anterior portion of the seventh rib to the tenth rib at the posterior axillary line. Temperature 99 deg. in rectum, pulse 88. Abdomen moderately distended. No broken ribs. The face was pinched, but there was no pallor, restlessness, or thirst. Fifty hours after injury the temperature was 99, pulse 90. There were no symptoms of progressive hæmorrhage, and the man's condition was considered to be improved. Yet the history and the anxious expression of the face, and the distended and rigid condition of the abdomen, led to the belief that the liver was ruptured, and justified laparotomy. On opening the abdomen, it was found full of dark fluid blood. An irregular rupture of the liver surface three inches in length was found, situated low down in the right lobe, and so far posteriorly as to preclude repair by sewing or cautery. There was some oozing from the wound, but not so active as to cause immediate alarm. The abdomen was flushed out with hot saline, a Mikulicz tampon was passed down to and into the wound, and gauze was carefully packed into it. This seemed to control the bleeding. The patient went off the table in a moderate state of shock. Pulse 98, respirations 32. The tampon seemed to interfere with respirations to a considerable extent. The pulse, temperature, and respiration continued to rise, and the patient died eleven hours after operation. At death the pulse was 120, respirations 45, and temperature 105 deg. The case presented some unique features. There was at no time any evidence of shock, nor at any time were there symptoms generally regarded as indicative of progressive internal hæmorrhage. The persistent rise of temperature after operation would argue strongly against the assumption that bleeding had not been arrested. Hyperpyrexia at death is usually regarded as due to exaggerated or disturbed metabolism, and the author considers that perhaps it can be explained in this case by the disturbance of the peculiar function the liver has as an internal secreting organ. S.

Mobility of the Kidneys.—H. Mackenzie (*Lancet*, Oct. 16th, 1907) discusses the cause and frequency of this condition. Of 113 cases operated on by fixing the kidney, 80 were completely successful, 17 were partially successful, 13 were failures, and 3 died as the result of the operation. The author believes that movable kidney is undoubtedly a very common condition, in the female subject especially so; that in the

great majority of cases it produces no symptoms, and that it requires no treatment when local symptoms are absent. When local symptoms are present, a fair trial should first be made with non-operative methods of treatment. Only when such methods have failed to relieve, or when there is good reason to believe that the kidney may be the seat of disease, should recourse be had to operation. The operation should consist in exposing and thoroughly examining the kidney for any traces of disease, and, should none be found, fixing the kidney in a thorough manner back into the loin.
G.

Tumours of the Bladder.—Kolischer (*Jour. Am. Ass.*, July, 1907) gives his experience in the treatment of vesical tumours. He holds that all cases of benign tumours of the bladder should be approached from within, all malignant tumours from the outside of the viscus. In all malignant cases in which the loss of substance is not too great, the bladder should be closed completely by sutures after the removal of the tumour. In cases of malignant growths, the incision into the bladder should be made in accordance with the location of the growth, as defined by a previous cystoscopic examination. The permanent catheter should be absolutely abolished after such operations on the bladder. It causes much irritation, and does no good. It is far better to pass a catheter at regular intervals into the bladder than to leave one tied in. Gas anæsthesia should be employed exclusively. A constant cystoscopic surveillance should be maintained over any bladder that has ever been operated on for tumour. In cases where the tumour is malignant and too far advanced to permit of any radical treatment, the bladder may be opened and the growth freely cauterised with an actual cautery. This, however, seldom gives more than temporary relief. The method of treatment which furnishes more satisfactory results, consists in establishing permanent kidney fistulæ, and thus preventing any urine passing into the bladder.
G.

A Method of Cystopexy for Cystocele.—L. Smith describes (*Montreal Med. Jour.*, April, 1907) an operation for this condition, which is easy to perform, and in his hands has given most successful results. The abdomen is opened just above the symphysis pubis, the bladder is seen lying low down in the pelvis, and must be gently grasped by a bullet forceps, and drawn up as high as it will go, without employing any force. Both the peritoneal surfaces on the bladder and on the anterior abdominal wall are scarified or criss-crossed with a needle, until there is a slight oozing of blood. A curved needle is then passed through the abdominal wall, including all the layers except the skin and fat. It is then passed under the scarified surface on the bladder wall, care being taken only to include the peritoneal and muscular coats, and not to injure the mucous coat. The needle is again passed through the abdominal wall at the other side of the raw peritoneal surface. Three similar sutures are passed, each of medium chromicised catgut, which should last for about a month without absorbing. No precautions are necessary with regard to emptying the bladder. As a rule the patient can do this without the help of a catheter from the very first.
G.

Doctor Dies of Cocaine.

Dr. John Ernest Cook, aged thirty-eight, unmarried, and practising at Darnley Road, Hackney, was found dead in his dining-room on November 6th, and the coroner's inquest, held on Saturday, showed that he had died from cocaine poisoning.

Witnesses said that Dr. Cook had been doing well in his practice, but he suffered much from neuralgia, rheumatism, insomnia, and other trying complaints, and twelve months ago he had to be treated by another medical man for an excessive dose of cocaine. He had never spoken of suicide, and left no written statement.

When found he was lying on the hearthrug beside an overturned chair, and the gas lights were burning.

After hearing the evidence, the jury found "Death from misadventure."

NEW BOOKS AND NEW EDITIONS.

The following have been received for review since the publication of our last monthly list:—

Sidney Appleton (London).
The Diseases of Infancy and Childhood. By L. Emmett Holt, M.D., Sc.D., etc. Illustrated. Fourth Edition, revised and enlarged. Pp. 1,171. Price 25s. net.

Bailliere, Tindall and Cox (London).
Cancer. By G. Sherman Bigg, F.R.C.S.Edin., M.R.C.S.Eng., L.S.A. Pp. 85. Price 3s. 6d. net.

John Bale, Sons and Danielsson, Ltd. (London).
Syphilis in the Army. By Major H. C. French, R.A.M.C. Pp. 126. Price 6s. net.

Adam and Charles Black (London).
Black's Medical Dictionary. Edited by John D. Comrie, M.A., B.Sc., M.B., L.R.C.P. Third Edition. Illustrated. Pp. 856. Price 7s. 6d. net.

Church of England Temperance Society (London).
Side-lights on Alcohol and its Action on the Human Organism. By "Medicus Abstinens." Pp. 185. Price 2s. 6d net.

Churchill J. and A. (London).
The Operations of Surgery. By W. H. A. Jacobson, M.Ch. Oxon., F.R.C.S., and R. P. Rowlands, M.S.Lond., F.R.C.S. Fifth Edition. Volumes I and II. Pp. 2,055. Price 42s. net.
The Book of Prescriptions (Beasley), with an Index of Diseases and Remedies. Rewritten by E. W. Lucas, F.I.C., F.C.S., with an Introduction by Arthur Sullivan, M.A., M.D., L.R.C.P. Ninth Edition. Pp. 366. Price 6s. net.

L. N. Fowler and Co. (London).
Medical Astrology. By Heinrich Däath. Pp. 108. Price 1s. net.

Charles Griffin and Co., Ltd. (London).
Medical Ethics: A Guide to Professional Conduct. By Robert Saundby, M.D.Edin. Second Edition, enlarged and rewritten. Pp. 144. Price 7s. 6d. net.

William Heinemann (London).
The Prolongation of Life. By Elie Metchnikoff. English Translation. Edited by P. Chalmers Mitchell, M.A., D.Sc., etc., etc. Pp. 343. Price 12s. 6d. net.

Homœopathic Publishing Co. (London).
The Enthusiasm of Homœopathy. With the Story of a Great Enthusiast. By John H. Clarke, M.D. Reprinted from the Journal of the British Homœopathic Society, January, 1907. Pp. 51.

Henry Kimpton (London).
Blood Examination and its Value in Tropical Disease. By Claude F. Fothergill, M.R.C.S., L.R.C.P., etc., etc., with a Preface by Major Ronald Ross, F.R.S., C.B. Pp. 34. Price 2s. 6d. net.

H. K. Lewis (London).
Squint and Ocular Paralysis. By E. Lucas Hughes, M.R.C.S. Eng., L.R.C.P.Lond. Illustrated. Pp. 206. Price 6s. 6d. net.
The Preservation of Infant Life. A Guide for Health Visitors by Emilia Kanthack. Pp. 92. Price, 1s. net.
Reminiscences in the Life of Surgeon-Major George A. Hulton, with an Introduction, by R. Lawton Roberts, M.D., J.P. Pp. 224 Price, 5s.

Longmans, Green and Co. (London).
The Reduction of Cancer. By the Hon. Rollo Russell. Pp. 62. Price 1s. 6d. net.
Text-Book of Organic Chemistry for Medical Students. By Dr. G. V. Bunge. Translated with Additions by R. H. Aders Plimmer, D.Sc.London. Pp. 260. Price 6s. net.

Macmillan and Co., Ltd. (London)
A System of Medicine. By Many Writers. Edited by Thomas Clifford Allbutt, M.A., M.D., LL.D., D Sc., F.R.C.P., F.R.S., F.L.S., F.S.A., and Humphry Davy Rolleston, M.A., M.D., F.R.C.P. Volume III. Pp. 1,040. Price 25s. net.

The New Sydenham Society (H. K. Lewis) (London).
The Atlas of Clinical Medicine, Surgery, and Pathology. Fasciculus XX. and XXI., Small-Pox. Fasciculus XXII. and XXIII., Variola and Varicella. Fasciculus XXIV., Eczema, Gout, Ringworm, etc. Annual Subscription, £1 1s.
Selected Essays on Syphilis and Small-Pox. Edited by Alfred E. Russell, M.D.Lond., M.R.C.P. Illustrated. Pp. 215.

Nisbet, James and Co., Ltd. (London).
Cancer of the Stomach. By A. W. Mayo Robson, D.Sc., F.R.C.S. Pp. 218. Price 4s. 6d. net.

G. P. Putnam's Sons (London).
Diagnosis of Organic Nervous Diseases. By Christian A. Herter, M.D. Revised and enlarged by L. Pierce Clark, M.D. Pp. 690. Price 12s. 6d. net.

W. B. Saunders Co. (London).
Surgery: Its Principles and Practice. By Various Authors. Edited by W. W. Keen, M.D., LL.D., etc., etc. Vol. II. Illustrated. Pp. 920. Price 30s. net.

Taylor and Francis (London).
Appendix XXI. to the Second Edition of the Descriptive Catalogue of the Pathological Specimens contained in the Museum of the Royal College of Surgeons of England. By Samuel G. Shattock. Pp. 50.
Calendar of the Royal College of Surgeons of England, 1907. Pp. 378. Price 1s.

John Wright and Co. (Bristol).
Pelvic Inflammations in the Female: Being the Ingleby Lectures delivered at the University, Birmingham, May 9th and 16th, 1907. By Thomas Wilson, M.D.Lond., M.Ch.Birm., F.R.C.S.Eng. Pp. 66. Price 3s. 6d. net.
Physical Methods in the Treatment of Heart Disease. By Arthur G. Dampier-Bennett, M.R.C.S.Eng., L.R.C.P.Lond. Pp. 111. Price 3s. 6d. net.

NOTICES TO CORRESPONDENTS, &c.

☛ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

DAKHYL v. LABOUCHERE.

A DISCLAIMER.

To the Editor of The Medical Press and Circular.

Sir.—The name of "Dr. Cheetham" in association with the Drouet Institute having cropped up and been mentioned to me by patients, I beg to say, as the only medico of that name in practice in London, that I am not, and never have been, connected in any way with any of the parties, and send this disclaimer to remove what impression my patients and the general public have received against my strictly ethical career for 16 years at this address. S. W. Cheetham.

233 Romford Road, Forest Gate, E.

Christian Science denies the existence of illness, but the report in the "Christian Science Sentinel" of a meeting at Dixon, Illinois, is headed Dixon, Ill.—*Star.*

POISONOUS ENAMEL IN RECEPTACLES FOR FOOD.

A special report has been issued by the Home Office on the coating of metal with lead or a mixture of lead and tin. It deals with the effects of employment in the enamelling of metals and in tinning processes. It recommends that the addition of lead to the covering mixture in the tinning of iron and metal hollow-ware should be prohibited. Prohibition meets among other things the dangers such as that common tinned utensils may constitute a danger to the consumer. After treating of precautions, the application of exhaust ventilation, and other points, the report submits a draft of proposed regulations which define the duties of both employers and persons employed.

R. A.—We shall be happy to publish a letter on the subject if you will write one and keep it within moderate bounds as to the length and tone. We can only take general responsibility under the circumstances, and give you the opportunity of replying if you think your position has not been fairly represented.

M. D. Black.—We are sorry not to be able to do as you wish, but you will admit surely that it is reasonable. We really cannot write to the gentleman in question and remonstrate, however heinous his conduct. It may be a matter for the General Medical Council, the Medical Defence Union or some such body; but why for us?

Mr. H. Morton.—The populations of the five cities referred to, a given officially by the Registrar-General, are:—Birmingham, 553,155; Leeds, 470,268; Manchester, 643,148; Liverpool, 746,144; Sheffield; 455,553. Of these, during the month of October, Liverpool had the, highest death-rate, closely pressed by Sheffield.

LAST WORDS OF MEDICAL MEN.

"S. W." sends to the *Westminster Gazette*, on "The Last Words of Medical Men," the following historical instance of a patient's last words to his medical man:—M. de Calonne, one of the last Ministers of Finance of Louis XVI., in his last illness asked for a pencil, and wrote down the following words for the benefit of the doctor who attended him: "Docteur, vous m'avez assassiné! Si vous êtes un honnête homme, renonçez, à la médecine pour jamais."

Meetings of the Societies, Lectures, &c.

Wednesday, November 13th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. M. White: Clinique. (Surgical.) 5.15 p.m.: Lecture: Mr. D. Armour: Head Injuries.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks). 4.30 p.m.: Demonstration:—Mr. Brooks: Selected Eye Cases.

Thursday, November 14th.

Royal Society of Medicine (Obstetrical and Gynæcological Section) (20 Hanover Square, W.).—7.45 p.m.: Specimens will be shown by the President (Dr. H. Spencer), Mr. A. Doran, Dr. Fairbairn, Dr. Macnaughton-Jones, and Dr. C. H. Roberts. Paper:—Dr. T. Wilson: Pubiotomy (with illustrative cases).

United Services Medical Society (Royal Army Medical College, Millbank, S.W.).—8.30 p.m.: Paper:—Major W. S. Harrison, R.A.M.C.: Enteric Fever in War.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. F. B. Jessett: Carcinoma of the Uterus, the Importance of Early Diagnosis; Symptoms and Treatment.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappell). 5 p.m.: Demonstration at the Mount Vernon Hospital, Hampstead, N.W.:—Dr. J. E. Squire: Selected Chest Cases.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Tuberculosis of the Skin: I., Lupus Vulgaris; II., Tuberculosis Verrucosa Cutis; III., Scrofuloderma.

Hospital for Sick Children (Gt. Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Colman: Splenic Enlargement.

Friday, November 15th.

Society for the Study of Disease in Children (11 Chandos Street, Cavendish Square, W.).—4.30 p.m.: Cases will be shown by Dr. Clutterbuck, Dr. G. Carpenter, Dr. F. J. Poynton, Mr. J. R. Howard, Mr. R. Warren, and others. Paper:—Dr. G. H. Lock: Case of Rheumatic Hyperpyrexia in a Child aged Six Years.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Dr. J. Horne: Clinique. (Throat.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Outpatient (Mr. H. Evans). 2.30 p.m.: Surgical operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Great Northern Central Hospital (Holloway Road, N.).—3 p.m. Clinical Lecture:—Mr. G. Coats: Some Points in the Diagnosis and Treatment of Conjunctivitis.

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—3.45 p.m.: Demonstration:—Dr. D. McKenzie: Thyroid and Cervical Region.

Appointments.

Luard, H. B., M.B., B.C., D.P.H.Cantab., Certifying Surgeon under the Factory and Workshop Act for the Osmotherley District of the county of York.

Lupton, Harry, M.R.C.S., L.R.C.P.Lond., Consulting Surgeon to the Stratford-on-Avon Hospital.

Macdonald, Gilbert Reginald, L.R.C.P., L.R.C.S.Irel., Medical Officer for the Fourth District by the Wellington (Somerset) Board of Guardians.

Renton, J. Mill, M.B., Ch.B.Glasg., Extra Dispensary Surgeon to the Western Infirmary, Glasgow.

Roy, J. Allan C., M.B., Ch.B.,Vict., Assistant Medical Officer at the Royal Asylum, Cheadle.

Vacancies.

Ayr District Lunacy Board.—Medical Superintendent. Salary, £500 per annum, with house (unfurnished), fuel, light, water, vegetables, and washing. Applications to Mr. J. E. Shaw, County Buildings, Ayr.

Glasgow District Asylum, Woodilee, Lenzie.—Junior Assistant Medical Officer. Salary, £125 per annum, board, lodging, washing, etc. Applications to Dr. Marr, Medical Superintendent.

Haverfordwest Rural District Council.—Medical Officer of Health. Salary, £150 per annum, inclusive of all expenses. Applications to John E. H. Rogers, Clerk, 7, Dew Street, Haverfordwest.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary, £160. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26, Mosley Street, Newcastle-on-Tyne.

Peckham House Asylum, London, S.E.—Junior Assistant Medical Officer. Salary, £150 per annum. Applications to the Resident Licensee.

Parish of St. Giles, Camberwell.—Assistant Medical Officer for their Infirmary, Brunswick Square, Camberwell. Salary, £140 per annum, with apartments, board, and washing. Applications to Charles S. Stevens, Clerk to the Guardians, Guardians' Offices, 29, Peckham Road, S.E.

Births.

Corner.—On Nov. 9th, at 37, Harley Street, London, W., the wife of Edwd. M. Corner, M.C., F.R.C.S., of a daughter.

Simson.—On Nov. 8th, at 35, Cheyne Court, Chelsea, the wife of Captain Harold Simson, R.A.M.C., of a son.

Speirs.—On Nov. 7th, at The Cedars, Diss, Norfolk, to Dr. and Mrs. H. Meredith Speirs—a daughter.

White.—On Nov. 2nd, at Kasauli, Punjab, to the wife of Capt. F Norman White, M.D., I.M.S.—a son. (By cable).

Marriages.

Denny—Hood.—On Nov. 7th, at St. Anselm's Church, Davies Street, Edward Henry Marland, second son of the late Edward Maynard Denny, of 11, Bryanston Square, London, to Barbara Mary, second daughter of Donald W. C. Hood, C.V.O., M.D., F.R.C.P., of 43, Green Street, Park Lane, London.

Turner—Keysell.—On Nov. 2nd, at the Parish Church, Ware, Olivier Polhill, M.R.C.S., etc., third son of R. Drysdale Turner, of San Remo, to Amy Charlotte (Cissie), only daughter of the late Francis P. Keysell, of Grove House, Cheshunt, and Mrs. Keysell, Ware, Herts.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

Property in Museum Specimens.

A LAWSUIT in Sydney has raised an interesting and discomforting question for pathologists. It is a well-known maxim of the British law that there is no property in a corpse, though as a matter of fact public opinion, which is stronger than any law, would not for a moment allow anyone but the relatives of a deceased person to have possession of his body. Now, if there is no property in a thing, presumably there can be no property in, and consequently no theft of, its parts. There is then no harm in the removal of diseased portions of a body for museum specimens, and equally—and this is the discriminating point—there is no harm in anyone walking off with these specimens whenever they choose. Does a tumour become property when it is taken from a dead body and placed in a jar of formalin? Apparently not, for in the case in question the plaintiff sued the police for detaining a jar containing a dicephalous child, which his father had bought twenty-two years previously for £27, and the judge non-suited him on the ground that there could be no property in a corpse. It is not pleasant to think than an enterprising stranger might remove John Hunter's Collection from the College of Surgeons' Museum, and that all the police in Bow Street could not raise a finger to stop him. But it might be possible to prosecute a scientific enthusiast of such a kind for stealing the glass jars and spirit, and even for damage to the jars. So that without mentioning the specimen within, possession might be recovered of the jar, from which the specimen could not be removed without causing malicious injury.

Homœopaths Again.

OUR esteemed contemporary, the *British Homœopathic Review*, is, we are sorry to say, pained by some comments of ours on the proceedings of the homœopathic meeting at Harrogate last summer. The ideas expressed at that gathering, though well known, it appears, to homœopaths for nearly a century, are "too novel and revolutionary for our grandmotherly medical journals." But, dense as is our own ignorance, we are told that there is one other journal which lags even behind us in knowledge of the truth about infinitesimals. Which journal that is we are not told, but says the editor, "our readers will have no difficulty in guessing." So that, after all, we are not as grandmotherly as we might be. Let us hope that as time goes on we may attain to the enviable position of this more mature progenitress. At present we can only envy its riper experience. The *British Homœopathic Review* thinks us very blind not to see the value of the minute doses of silica and other drugs in spa waters, but it is chiefly hurt that we should have treated lightly Dr. Proctor's "thoughtful remarks" about the combination of mystery and truth in homœopathy. Is there not mystery in all laws? "Can those who ridicule us because we cannot explain the law of similars, explain the action of the law of gravity? Why do bodies attract one another with a force inversely proportional to the square of their distances and directly proportional to their masses? Is there not mystery in this, and is not this a mystery that has led to everlasting discussion amongst astronomers? Is, then, this mystery a fit object for the laughter of our orthodox contemporary?"

Various Mysteries.

WE are not sure that we understand what is intended by "this mystery" in the last sentence, but if either the law of gravity or the laws of the attraction of bodies in space be meant, we hasten to assure our contemporary that from our school days upwards none of them ever suggested one merry thought. Life would have been more joyous if they had. We are not amused at mysteries *quâ* mysteries. For some, such as the mystery of holiness, we have the greatest respect; for others, such as the Druce mystery, we have but little. The greatest mystery about homœopathy is that since almost every one of Hahnemann's doctrines has by this time been denied by one or other of his followers, and some of them, we believe, officially abandoned by all, that the cult has any cohesive force remaining. But we have to thank our critic for one graceful concession. He quotes our remark that the "everlasting discussion that rages abut homœopathy . . . . . can lead to no useful result," and adds, "There is truth in this." We are obliged for the admission, and will endeavour to bear it in mind. Where real knowledge resides criticism will elucidate it; but where mystery is the bulk of the stock-in-trade discussion is about as useful in clearing it up as letting off pop-guns would be in dissipating a London fog. There always will be eccentric people who prefer the gloom of the fog to the sunshine of the mountain, and to them the arcana of homœopathy are likely to prove irrestibly attractive.

Human Sacrifice.

As an example of the bewildering state of the mind of the true homœopath, we cannot do better than refer to Dr. Burford's evidence before the Royal Commission on Vivisection, which is given in the same number of the *British Homœopathic Review*. It occupies some twenty-five pages, and the reader who can deduce from it much more than that Dr. Burford wishes drugs to be tried on man rather than on animals, is possessed of greater subtlety of intellect than ourselves. Dr. Burford, a homœopathic practitioner, came before the Commission as representative of the "World League of

Opponents of Vivisection," and after having answered nearly a hundred questions, said that he could not say whether the views he expressed were those of the League he came to represent or not! He believed, however, that they wished the subjects of experiments with drugs to be men and not animals. New surgical operations and new suture material, and so on, he thought, also, should be tried on man before being tried on animals. Besides these extraordinary doctrines Dr. Burford held that experiments on animals had greatly advanced physiological, pathological, and diagnostic knowledge and skill, and that though he would restrict experiments on animals with drugs to such as had been performed on man previously, he would not abolish the practice, and he was not sure whether he would abolish physiological demonstrations on animals to students. Moreover, he thought that serumtherapy had been of great use, and had been discovered by experiments on animals, and though he could not suggest how it could have been discovered otherwise, he believed there was no reason why it should not have been found out by homœopathic methods. How anyone holding such views can represent a League of Opponents to Vivisection, or how he can expect to get serum from animals except by experiments on animals are points that take the breath out of the plain man's body.

Worcester C.C. and Medical Inspection. The opposition which the medical inspection of school-children will meet with if not conducted in accordance with parents' wishes is forcibly illustrated by an occurrence at Bromsgrove. The Worcester County Council have appointed a medical woman to inspect schools under the Education Committee, and it is alleged that she visited certain schools, inspected the heads of the children, and found 70 per cent. of them to be infected with lice. Cards directing the parents' attention to the fact and suggesting treatment were sent home by the children in unsealed envelopes, it is said. The parents were exceedingly angry, many of them denied the diagnosis, and one parent went to his own doctor in the evening and obtained a certificate saying the child's head was clean. On the next occasion of the lady's visit a hostile demonstration was organised by the parents. The position was considered at a meeting of the Bromsgrove Education Committee, and the following resolution was sent to Worcester: "That this committee beg to call the attention of the Education Committee to the fact that considerable friction has been caused on the occasion of the inspection by the medical officer at the schools, and they view with alarm the manner in which the examination was conducted, and the careless way in which the warning cards were distributed."

Need for Tact. Now these proceedings seem to us to be precisely of the kind that may threaten the medical inspection of schools with the unpopularity that attached itself to compulsory vaccination. We are not in a position to judge of the correctness or incorrectness of the statements made, but it is quite clear that bad feeling has arisen, and unless the medical inspection of school-children attracts the gratitude and good-will of parents in bulk, this most useful provision will incur odium which may be fatal to it. It is not necessary to remind British readers that no method that smacks of autocracy or high-handedness or want of consideration will ever be acceptable to the working-classes; indeed, it would be a bad sign if it were. The question of dirty heads, as every medical man knows, is one which raises more indignation in a poor parent's breast than anything else, even when lice are demonstrably present. On the other hand, if a mistake be made, the indignation has good basis in fact. Only by the most tactful methods would it be possible to transform a school containing anything like 70 per cent. of lousy pupils into a thoroughly clean one; wholesale condemnation at one fell swoop would be likely to sap all the medical inspector's influence for good for ever.

LEADING ARTICLES.

THE RIGHTS OF HOSPITALS IN COMPENSATION AND OTHER CLAIMS.

THAT the services of honorary staffs are utilised in various ways by patients in enforcing claims for money from employers and from other sources is, of course, an established fact. We have often complained of the way in which public bodies like school boards obtain certificates gratis from the hospitals as to the fitness or otherwise of scholars for school attendance. We regard that as an unfair advantage taken of the hospital medical staff at the expense of their professional brethren outside. The hospitals have only to be firm and united in the matter and a considerable slice of legitimate income would be restored to the general practitioner, or, failing that, a small fee might be exacted by the hospital authorities for every such certificate granted by one of their staff. As to the average club certificate, there is little to be said in the case of poor patients, although in their case the document is asked for with the avowed object of entitling the holder to a more or less substantial money payment. Another kind of claim, however, has arisen of late, namely, those of domestic servants and workpeople under the Workmen's Compensation Act. At the present moment there is no knowing what may be the exact relation of any injury, trifling or severe, to a future claim. A mere trivial punctured wound, if sustained in the course of a labourer's occupation, may become septic and lead to prolonged sickness or death. In such a case the patient may be treated in the first place at a public hospital, and a certificate granted stating his disability to work for a few days on account of the accident. Should the after-course of affairs be of the untoward nature above indicated, then the hospital certificate, freely given in the first instance to help a working man tide over an apparently trifling emergency, would assume a vastly different importance as the chief documentary proof in establishing a claim for two or three hundreds of pounds sterling. More than that, a precisely similar train of reasoning applies to almost all cases of sickness amongst workpeople in active occupation. The basis of the law of workmen's compensation has been so greatly broadened that at any moment a great number of maladies may be asserted to have arisen directly or indirectly out of a particular occupation. Under these circumstances there seems to be good reason for all medical men engaged in honorary or resident hospital work to pay some attention to the question of certificates granted to patients of medical charities. Indeed, the subject might well be brought prominently before the professional bodies which deal with matters of practical politics. In point of fact, it is not altogether impossible to imagine that the medical charities may find on an enquiry that it would be desirable to refuse sick certificates in any shape or form. It is tolerably certain that such an action would to some extent relieve the unfair hospital competition of which general practitioners complain. As regards payments from patients to which the medical charities may be said to have a moral right, much attention has been drawn to the point by a recent action of Mr. Justice Darling. In a case before him in which damages were found against two motor omnibus companies for personal injuries caused to a lad, the Judge mentioned directed that, out of the sum awarded, a certain amount should be handed to the hospital where the injured boy was treated. In a letter to the *Times*, commenting upon that direction, Mr. Justice Ridley says:—"I quite concur with this, and think it right and proper; but I have often thought when trying cases of this kind, where injuries caused by the negligence of defendants have been treated free of expense to them in a hospital (instead of by a doctor for whose charges they would have had to pay), that it would not be unfair if the Court had power to add to the damages such a sum as they might, within certain limits, assess as a contribution to the hospital proper to be paid by those who did the wrong." Judge Ridley asks if it would not be possible for Parliament to find time for the passing of such a measure, short, beneficial, and non-political. Viewed in the light of past history, we fear no British Government is likely to favour such a proposal for generations to come. Even the present Government, which claims to be liberal and progressive in its social legislation, has recently saddled the medical profession with another gratuitous duty, to be discharged under pains and penalties, under the Notification of Births Act. On all hands it is evident that the economic relations of the hospitals, the public and the medical profession stand in urgent need of revision.

CURRENT TOPICS.

The Bristol Infirmary Dispute.

WHATEVER may be the upshot of the stand taken by the honorary medical staff of the Bristol Royal Infirmary against the attempt of the Board to interfere with their private affairs, it is encouraging to see the loyalty with which the local medical profession has rallied to their support. They have issued a temperate, clear and dignified address to the governors of the charity in question. They "view with dismay" the rule curtailing the holding of outside appointments and restricting the private practice of the honorary staff. If enforced, they say such a rule will inevitably lead to the resignation of the entire staff, and the disaster to this noble institution will be final and irremediable. They urge the governors to vote "against this most objectionable rule in its entirety." There are no fewer than 226 signatures to this document. It is a most gratifying sign of the times to see medical men coming forward collectively in defence of their reasonable rights and privileges. In the present instance their united action makes it practically impossible for the Board, supposing them to be stiffnecked and strong enough to carry their obnoxious rule, to replace the medical staff. It is inconceivable that any medical man would have the temerity to apply for one of the vacant posts in face of such a manifesto signed practically by the whole local profession.

Earth Fertilisation by Seed Inoculation.

A DISCOVERY of vast potentiality has been announced by Dr. Bottomley, Professor of Botany at King's College, London. It is nothing less than that of the fertilisation of soil by inoculating seed with a nitrogen-producing microbe. The possibility of turning barren land into fertile fields thereby afforded is certainly alluring, for it satisfies a scientific dream that has long haunted the mind of mankind. The present announcement bears all the air of authenticity and of well-ascertained results. It is stated, for instance, that a small holder near Gloucester "inoculated" a quarter of an acre of peas, from which he obtained 33½ pots of peas, selling at £7 18s. 9d., as against .14 pots, selling at £2 5s. 6d. from a similar area dressed in the ordinary way with 1 cwt. of superphosphates and sulphate of potash. It is further said that Mr. W. T. Stead, the well-known journalist, has acquired the exclusive right of handling the new material for twelve months from January next, the same being supplied to him at the rate of 5s. a gallon. Mr. Stead's avowed purpose is not to make a fortune out of the monopoly, but to confer an enormous boon upon the United Kingdom by bringing many millions of acres of barren land into cultivation. The Americans have a corresponding but greatly inferior article, the price of which is thirty shillings per gallon. Mr. Stead's price is six shillings, of which half will go to Dr. Bottomley and the other half to advertising and pushing the sale of the stuff. If there be any surplus to dispose of, he proposes to endow a professorship for biological and botanical research. It is to be hoped that there is a more practical and substantial foundation for this "discovery" than for that announced from the Continent a year or two ago, whereby agriculture was to be revolutionised all over the world. Dr. Bottomley's researches appear to have been founded on the original observations of Hellneght, in 1886, upon the relation of bacteria to the roots of leguminous plants.

A Sign of the Times.

IF there be any truth in the proverb that coming events cast their shadows before them, then there is something of significance in the proposal of the medical staff of the Montrose Royal Infirmary to charge fees to certain patients in that institution. This is indeed taking the bull by the horns, and although the suggestion was not adopted by the management, it nevertheless gave rise to considerable discussion. The staff appear to have confined their proposal to private patients sent by themselves to the hospital. As a general rule, the established ethical usage in the medical profession is scrupulously to avoid anything remotely suggesting a fee to hospital patients, and it is not a little startling to hear a plan for systematic payment coming from a medical quarter. The objections to such a course can hardly be otherwise than abstract and sentimental. If the whole matter be resolved into a logical analysis, one of the fundamental points will be the definition of a hospital, and whether a medical charity is founded for the benefit of those who can pay fees. If the hospitals attract and foster patients who can pay fees, are not medical men entitled to be paid for their services? On what grounds do the hospitals use funds collected for the poor for the purpose of relieving the well-to-do? These questions have long vexed the mind of the general practitioner, but Montrose has presented them for the first time in concrete form.

Sylvester's Method v. Schafer's.

SOME very interesting experiments on the comparative value of Dr. Sylvester's method for resuscitation of the apparently drowned, and that recently introduced by Professor Schäfer, were made at the London Hospital last week. Mr. W. M. Fletcher, of Trinity College, Cambridge, lectured at that institution on behalf of the Royal Life-Saving Society, and thereby attracted the attention of the staff and students to the new method. It was accordingly arranged that a trial should be made of the two plans, several students offering themselves as subjects for the experiment. The tests were carried out under the supervision of Dr. Keith and Dr. Leonard Hill in one of the small operating theatres. The experimentee had his face covered with an india-rubber mask to which was attached an india-rubber tube communicating with a spirometer. The experiments consisted of two minutes' successive trial of the two methods, the student endeavouring not to breathe voluntarily during the ordeal. No marked difference was obtained by the test, but it was admitted to be unsatisfactory because of the difficulty of excluding voluntary efforts. Consequently it was decided to anæsthetise a volunteer and make the experiment again. Although the conditions were, of course, very different from those obtaining in a person apparently drowned, the result showed a marked difference in favour of the older method. The respiratory exchange shown by Sylvester's plan mounted to between 500 to 600 cubic centimetres, whilst under Schäfer's it was not more than 300 to 400, and sometimes only 200. Although Schäfer's method is certainly more convenient in many ways, and less exhausting to the operator, it would seem that it is not so effective in filling the lungs with air and conducting the exchange.

Dakhyl v. Labouchere.

THE echoes of the Dakhyl *v.* Labouchere case have not been so loud and frequent as the extensive reports given to the proceedings by most of the newspapers seemed to presage. *Truth* is naturally pleased, but it treats its opponent in a very magnanimous manner, even expressing sympathy that he has been put to so much expense. We have already congratulated our contemporary, but we cannot help reverting to the commendable persistency with which Mr. Labouchere refused to take the first, and obviously ridiculous, verdict against him, and fought the case through to a finish. No one will lose faith in a quack of the rankest species if denounced merely in a medical paper, and Mr. Labouchere has silenced a number of the most blatant of them in the course of his journalistic career. Indeed, the very rules by which medicine seeks to control boastful pretenders in its own ranks are resented by the public. We are specially glad, then, to call attention to one sentence in *Truth's* article on the subject. It runs: "My observations on the Drouet Institute, as well as on Dr. Dakhyl, were prompted by regard for the interest of the public, not of the medical profession, *but in the main the two interests are identical.*" [The italics are our own.] That point we have maintained over and over again, but the public will never admit it. Such articles as appeared in other journals dealt very gingerly with the topic. It is a delicate one for most of them, as the main advertisement revenue of most is derived from fraudulent quack announcements. We fancy that many journals anticipated a repetition of the first verdict, and would have been glad to enlarge on the exclusiveness of the profession in having no truck with men of the Dakhyl type. As the verdict was against that individual they were content to evaporate into generalities about the exact definition of a quack, and similar banalities. It is a shocking thing to reflect that nearly the whole of the great development of journalistic enterprise of the last thirty years is built upon the most pernicious form of extorting money from the poor, namely, by gross lying to them about their health on which their livelihood depends.

A Round Robin.

That the Midwives Act is running a chequered career is being demonstrated almost every week. One of the most serious attacks on its administration was announced a few days ago by Mr. Coroner Baxter at a Poplar inquest. The investigation was concerned with a child who died a few hours after birth. The Coroner mentioned the fact that he had received a round robin from medical men, refusing to attend cases where there had been a midwife or "handy woman." It is impossible to avoid a feeling of sympathy with qualified medical men who decline to be made the instruments of deliverance from the Nemesis of unskilled or partially-skilled midwifery. The Legislature appears to have reckoned without their host in passing the Midwives Bill. The medical practitioner, against whom they were pitting an ignoble rival, was expected to take his part in the programme without demur. If he follows to any great extent the example of the Poplar practitioners, the Midwives Act will speedily become a dead letter, for the public will have to choose between medical men and midwives. There will be no half-way house if the medical profession make up their mind to unite against this insidious form of unqualified competition.

Sanitation in Irish Schools.

Some appalling information as to the condition of the buildings of the primary schools was given the other day in a public speech by Mr. Starkie, the Resident Commissioner of National Education and official head of the primary school system in Ireland. Everyone must agree in the view that it is of the utmost importance to the health of the nation that the schooling of the young should take place under proper sanitary conditions—that the school buildings should be clean, bright and airy, and that the children should learn something of hygiene, not merely from perfunctory primers, but from practical example. The Resident Commissioner, however—and he ought to know—is reported to have said: "They saw in the schools insufficient floor space, insufficient heating, insufficient class-rooms, and no means of cleanliness such as the simple form of lavatory. One of the inspectors, reporting as to a school in Ballymacarrett, Belfast, stated that on the day of inspection there were 401 pupils crowded on a floor space intended only for 209. There were 61 first standard pupils in a room 14 by 9½ feet, or 133 square feet in all. In another room there was 1¾ square feet for each unit. Thus the Belfast class-room was not as bad as the Black Hole of Calcutta by one quarter of a foot for each unit." We understand that attendance at school is compulsory in Belfast. It is hardly necessary to comment on these scandalous facts. The cruelty of compelling children to herd together in this fashion for some five hours a day is only equalled by its folly. Education is supposed to be given for the advantage of the child. In what possible way can a child be benefited by instruction given under such conditions at the expense of the health of its life-time? At no period of life are hygienic conditions more necessary than in childhood. It would be out of comparison better to let children grow up unable to read, write, or cipher than attempt to teach them under the conditions that obtain in Belfast.

The Dublin Hospitals and Tuberculosis.

A step of considerable importance has been taken by Her Excellency the Countess of Aberdeen in endeavouring to establish special dispensaries for consumption in Dublin. At present there is no special dispensary for consumption, and tuberculous patients attend the Poor-law dispensaries and dispensaries of the clinical hospitals along with other patients. Her Excellency as President of the Women's National Health Association, has written to the several hospitals of Dublin, asking each of them to consider the possibility of starting, on one day in the week, a special dispensary for tuberculous patients. By this means, there would be on each day of the week a special dispensary within reach of any part of the city. If this were done, and a record of the patients kept, the Women's National Health Association would, on its part, guarantee to send visitors to the patients' homes who would give instructions as to the means to be adopted to prevent the spread of the disease. The various hospital boards have the matter at present under discussion, and we are unable to say at what decision they will arrive. It is probable that in the first instance a conference representing the various hospitals will be held. The plan is in many ways a good one, and should add little to the expense of running the existing out-patient departments, though it is to be remembered that under present circumstances the chance of infection being spread by allowing tuberculous and other patients to attend the same dispensaries is slight. An alternative scheme, but one probably more expensive, would be to establish a central out-patient department, which might be worked in connection with the Royal National Hospital for Consumption.

Bob Sawyer Redivivus in Paris.

The medical student of to-day is a being far removed from the days of Albert Smith or Dickens. He is no longer the rollicking, rowdy trifler with snatches of work, but has become a serious, sober, hard-working lad, with brief intervals devoted to physical exercise. Now and then, it is true, there are scenes of disorder at some of our universities, chiefly in those north of the Tweed, at opening lectures and rectorial addresses. Collisions with the police, which used to take place occasionally at snowballing fights or torchlight processions, have not been heard much of lately. In Paris, however, the spirit of Bob Sawyer appears to linger. Two university professors appointed from the town of Nantes did not meet with their approval, and they proceeded to pelt them with tomatoes, eggs, and stale vegetables on their first appearance in the lecture-room. Outside, the mob of students were encountered by the police, who headed off the ringleaders, and thereby promptly quelled the disorder. The Paris University authorities have adopted the drastic step of closing the faculty until the end of the year. An exception is made in the case of students who, under ordinary circumstances, would have graduated before December 1st. The reason of this is that failure to pass within the prescribed date would entail an extra year of military service. The students demanded professors from the Paris schools, and resented those from the provinces.

PERSONAL.

H.I.H the Kaiserin visited the German Hospital at Dalston on November 14th, and conversed with some of the patients.

Her Royal Highness the Duchess of Albany opens the Infants' Hospital, Vincent Square, Westminster, to-day (Wednesday), at 3 p.m.

Dr. Ironside Bruce has been appointed Radiographer to Charing Cross Hospital, in place of Dr. Mackenzie Davidson (resigned).

Principal Donald MacAlister will preside at the session of the General Medical Council which opens on Tuesday next at 2 p.m.

Dr. Arthur E. Boycott, Fellow of Brasenose College, Oxford, has been awarded the Radcliffe Prize for 1907. Dr. A. G. Gibson received honourable mention.

Mr. Haffkine and Dr. Ashburton Thompson will read papers on "Plague" at the Epidemiological Section of the Royal Society of Medicine on December 2nd at 8.30 p.m.

Dr. A. H. Spurrier has been granted the Royal permission to wear the insignia of the Second-Class Order of the Brilliant Star of Zanzibar conferred on him by the Sultan of Zanzibar.

A former President of the Lower House of the Austrian Reichsrath, Count Vetter von der Lille, who is over 50 years of age, has recently graduated as M.D. at the University of Vienna.

Dr. James Little, Regius Professor of Physic in the University of Dublin, has been appointed by the Crown to be a member of the General Medical Council for a further period of five years.

Sir James Digges La Touche, K.C.S.I., and Sir Shirley F. Murphy will be the guests of the Irish Medical Schools' and Graduates' Association at their dinner on Wednesday, November 27th, at the Hotel Cecil, London, W.C.

Dr. J. R. Bradford has been appointed Examiner in Medicine at Oxford; Professor Howard Marsh, Examiner in Surgery; Dr. J. W. Eden, Examiner in Obstetrics; and Dr. T. M. Legge in Forensic Medicine and Public Health.

Dr. Koch, who has returned to Berlin after an absence of 18 months in German East Africa, has been promoted to the rank of Wirklicher Geheimer Rath, with the title of Excellency, in recognition of his valuable researches into the causes of the sleeping sickness.

Mr. Rickman J. Godlee, F.R.C.S., Surgeon-in-Ordinary to H.M. the King, Surgeon to University College Hospital, will deliver the Bradshaw Lecture at the Royal College of Surgeons, England, on December 5th, the subject being, "The Prognosis and Treatment of Tubercular Disease of the Genito-Urinary Organs."

The period of office of Mr. Clinton T. Dent, F.R.C.S., as a member of the Court of Examiners, Royal College of Surgeons of England, having expired, the Council announce the vacancy in our columns to-day. Mr. Dent, however, is eligible, and will, we understand, offer himself for re-election.

A Clinical Lecture

ON

A REFERENCE TO SOME TUBERCULAR DISEASES OF THE KNEE JOINT AND TO THE TREATMENT OF THE SYNOVIAL CAVITIES.

By R. L. SWAN, F.R.C.S.I.,

Surgeon to Dr. Steevens' Hospital and to the Orthopædic Hospital, Dublin.

Gentlemen,—You have seen in this hospital a number of cases of disease of the knee-joint, differing in their onset; in their appearance; and their clinical symptoms, to which the generic term "tubercular" was applied. Many of those, although springing from the same ætiological factor, were as varied, as regards the tissues involved and the appropriate treatment, as if in each case a different disease existed. In the limited time at my disposal I shall only touch on the outskirts of this subject, in an effort to illustrate some diagnostic features in tubercular disease of the knee, and, so far as is yet known, the most successful methods of dealing with some of its forms.

For practical purposes, we may broadly divide tubercular disease of this region into two varieties: (1) Of the bones; (2) of the synovial membrane, recognising the fact that as the focus, wherever originally placed, has a progressive tendency, both structures may become involved from disease of either.

There are three situations towards which the osseous focus may extend:—

1.—Outside the limits of the synovial membrane.

2.—At the point of reflection of that tissue.

3.—Towards the articular surface, and by absorption of the cartilage, directly infecting the joint.

1. The local signs will be marked. There will be pain and lameness, and an abscess will develop. The joint, however, although sometimes showing effusion, may altogether escape infection. In such cases close attention to surgical details, especially to drainage, and the use of bactericidal injections are of great value.

2. Here the synovial membrane becomes thickened at the point of infection. This condition spreads through its entire extent, and abscess at the point of primary infection is not infrequent.

3. The train of symptoms following direct infection of the joint through the eruption of a softened tubercular focus through the cartilage are acute. There is severe pain, and the entire joint is soon infected.

The frequency with which tubercular disease originates in the synovial membrane and in the bone is somewhat greater in the first (351 synovial and 281 osseous—König). In the 281 cases referred to the patella was affected in 33, the femur in 97, the tibia in 107, and several bones 48. Primary foci in the patella may soften and burst externally, but frequently cause infection of the joint. Granulation foci may be met with near the femoral condyles, and most frequently the internal, which is also the seat of extensive tubercular lesions in children. These do not infect the joints so frequently as in adults, but develop toward the surface. Large tubercular deposits are often met with in the head of the tibia, sometimes softened and large enough to merit the name of caseous abscess. Tubercular foci may remain latent in bone for a prolonged period, and may undergo change into a calcified and desiccated tissue. During the period of primary deposition the symptoms are vague. There is little or no pain; there is a feeling of fatigue, and sometimes an effusion into the joint, which subsides when rest is enforced.

If the fortunate result of calcification of the focus occurs, there are no further symptoms.

I shall not here allude at all to the treatment of knee joint disease associated with osseous lesions. I have nothing new to mention, and you have constant opportunities of seeing the application of erasion, excision, or general surgical principles to those cases.

Hydrops Tuberculosis.—Chronic synovitis, scrofulous synovitis, recurrent synovitis of the older authors is frequently met with. It is most common in early youth and young adults, but may be seen in persons of middle age. Its origin may be ascribed to some trivial injury. The joint may be enormously distended, and the synovial membrane has been known to rupture spontaneously (Nélaton): "Under the influence of rest and treatment, the swelling usually subsides, to reappear when walking is resumed."

Degenerative changes in the diseased synovial membrane usually occur as time goes on. A gradually increasing thickness is perceived, some pain after walking is felt, and occasionally a tendency in certain movements to locking of the joint. In such cases it will be found that masses of fibrin have been detached from the synovial membrane, and have become moulded by the movements of the joint into pyriform masses (melon seed bodies), floating in a grey or semi-opaque fluid mixed with shreds and flocculi of fibrin, a crepitating sensation being imparted to the fingers on examining the joint from the contact of those masses.

In some cases the synovial membrane is seen to be studded with polypoidal sessile masses, red on the surface, and secreting a sanious fluid; sometimes on removal of the fluid by rest it is possible to discern those masses, especially in the suprapatellar pouch.

Tubercular empyema of the knee is sub-acute in its nature, and is met with in persons of low vitality showing other signs of tuberculosis. An acute form of empyema is met with in young children, accompanied by pain and pyrexia. The synovial membrane is said to show miliary tuberculosis.

Synovial Fungus (White Swelling).—Those cases are happily not now so often seen, or only in cases (usually the children of the very poor) who have been neglected. An advanced condition of disease exists. It may either follow primary hydrops, or commence with initial signs of synovial thickening. There is generally pain referred to the tibia or the centre of the joint. The pain may be intermittent, and is mostly felt at night. The synovial membrane progressively thickens. The knee attains a large size. The skin is shining, with blue veins ramifying on it. Later on the cartilages become involved, and suppuration occurs.

It is in disease of the synovial membrane that we may hope to restore functional usefulness to the joint in many cases.

Several methods have been adopted.

1st.—Most surgeons recommend that the flexed position usually existing should at first be rectified by extension, followed by prolonged fixation for 12 or 18 months.

2nd.—Venous congestion by Bier's method.

3rd.—Injections of iodoform glycerine into the joint. It may be remarked that the first method does not aim at functional restoration of the joint, and owing to the time involved is not applicable to the poor.

With regard to Bier's method and iodoform glycerine injections, the results are not satisfying. Evidence in the subject shows in some cases improvements, in others none.

In the year 1904 I read a paper at the Surgical Section of the Royal Academy of Medicine, showing the results of the application of pure carbolic acid to the interior of the joint in tubercular synovial disease, and describing the method of operating. Since that time I have treated numerous cases with very satisfactory results. It is applicable not only to recurrent hydrops, without synovial thickening, but also to the fibrinous form of tubercular disease, to the vascular and polypoidal disease of the synovial membrane, and to synovial empyema.

The only modification in the method of operating is the position of the incision, originally as described in my paper of 1904. I made a transverse section of the patella. Later on I adopted an incision of the inner side of the joint, but I have recently adopted the curved incision of trachea, at the outside of the joint, and have in some cases removed a piece of the tibia attached to the ligamentum patella, in order that full access to every part of the joint should be attained.

The restoration of function is usually complete, and, so far as I have seen, there has been no relapse. Only a few days ago I received a letter from a soldier in the Bedfordshire Regiment stationed at Jhansi, on whom I operated four years ago in this hospital. He says: "My knee never gives me any trouble, and I can march as well as anyone else." The following are a few illustrative cases:—

R. F., a shopkeeper from the West of Ireland, has been troubled with his knee for two years. There is considerable effusion, with some synovial thickening. In September, 1905, I opened the joint and gave exit to a whey-coloured fluid, with some shreds and fibrinous masses. The synovial membrane was roughened, and of an ashy grey colour. I washed out the joint, removing all the fibrinous shreds with a sterilised loofah, especially dealing with the sub-crureus bursa. Having dried the surface, from which a small quantity of blood was now oozing in some places, I applied pure carbolic acid freely with a stick, and again irrigated the joint, closing it without drainage. This man recovered perfectly—I saw him about a month ago. There was no trace of disease. Mr. E. was sent to me from Kilkenny by my friend Dr. O'Hanlon of Castlecomer. He had the usual symptoms of recurrent hydrops, and was in some anxiety about the possibility of retaining his situation owing to the frequency of his disablement. His knee had been affected for three years. When I saw him it was much swollen and somewhat flexed. Rest in bed was followed by subsidence of the swelling, which returned when walking was resumed. I advised operation, and with the assistance of Sir C. Ball, adopted the plan described above. Six months later he came in to show his knee, which, except for the scar of the operation, was indistinguishable from the other.

Mrs. R. C., a lady, æt. 32, from the South of Ireland, accustomed to an active life, has been two years suffering from her knee. I saw her in June, 1905, she was then unable to walk for any time without pain, and an increase of swelling in the joint, which was never quite free from effusion. An irregularly felt thickening of the synovial membrane was observed, especially in the suprapatellar bursa. She suffered some pain at night. I opened the joint on July 3rd. I found the interior of the synovial membrane of a purple colour and studded with sessile masses resembling purple grapes. The joint was filled with a red and oily looking fluid of the consistence of thin gum arabic. The synovial membrane was thickened and although apparently vascular, was not really so. The surface was subjected to a vigorous rubbing with sterilized loofah, irrigated and carbolic acid freely applied. In April, 1906, I received a letter from her husband stating:—"My wife is better than she has been for years. She can walk and ride as well as ever she did, and has no trouble with her knee."

J. S., a young man, æt. 23, in broken health, with scars of tubercular glands in the neck, was admitted into the Orthopædic Hospital (October, 1902). The knee showed a uniform swelling, was flexed and somewhat painful. On passing an exploring needle into the joint, a fluid resembling pus was withdrawn. The joint was incised, a large quantity of this fluid was withdrawn, the cavities thoroughly washed and rubbed, carbolic acid was applied, and it was closed without drainage. He made an uninterrupted recovery, and under the influence of good food and treatment, his general health became improved. I saw him some time ago; his knee showed no trace of disease.

The following condition may be mistaken for tubercular disease of the knee:—

1st. Syphilitic gummata.

2nd. Arthritis deformans.

3rd. Staphylococcus lesions from Brodie's abcess, either in tibia or femoral condyles.

4th. Charcot's disease.

5th. Gonorrhœal anthritis.

6th. A sarcoma, growing most frequently from the lower end of the femur.

7th. The non-tubercular form of loose cartilage.

8th. The bleeder's knee, met with in hemophiles.

Note.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by James Morrison, M.D Lond., Hon. Physician Accoucheur Farringdon Dispensary and Lying-in Institution. Subject: Lingering Labour; its Causes and Treatment."***

ORIGINAL PAPERS.

THE ANATOMY OF THE SO-CALLED

LIGAMENTUM PECTINATUM IRIDIS

AND ITS BEARING ON THE

PHYSIOLOGY AND PATHOLOGY OF THE EYE. (a)

By THOMSON HENDERSON, M.D. Ed., Ch.B.
Nottingham.

The author stated that the so-called pectinate ligament was a part of and belonged to the sclera. The principle on which it was constructed was perfectly simple, being exactly the same as that which obtained in the fibres of the neighbouring tissue in which it lay, as an open network, composed of non-sclerosed interlacing fibres, which were in direct continuation with the circular and longitudinal bundles of the sclera surrounding the venous sinus of Schlemm's canal. The circular fibres were made out in tangential and transverse sections of the pectinate ligament, while the longitudinal fibres were seen in radial sections. The criterion of a true radial section was that it showed the anatomical connection and continuation often suggested, but hitherto never yet demonstrated, of

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(a) Abstract of Paper read before the Ophthalmological Society, November 14th, 1907.

the hyaline layer of the ciliary body with the posterior limiting layer of the iris. Arising as a continuation of the innermost lamellæ of the cornea, the pectinate ligament should be divided into (1) a small outer or scleral portion, where fibres at the posterior end of Schlemm's canal became lost in those of the sclera, and (2) an inner larger or ciliary division, which could be still further sub-divided into (a) a portion which pierced the scleral ring to give attachment to the meridional fibres of the ciliary muscle, (b) a part which passed internally to the scleral ring to terminate in the connective tissue stroma of the circular portion of the ciliary muscle. None of the fibres of the ligament turned round into the root of the iris, as was described, but this appearance was the result of an oblique section and emphasised again the importance of studying only true radial preparations.

The iris root was attached to the circular bundles of the ligament at a point just posterior to the scleral ring, which attachment to the ligament was quite a different matter to fibres of the ligament being said to bend round into the iris, which they did not. He considered that the term ligamentum pectinatum iridis was thus not only altogether inappropriate but also wrong and misleading, as in man it was neither a comb-like structure nor was it a ligament to the iris. On this account, and because of its retiform or cribriform structure, and further, on account of it being a ligament in the true sense of the word to the two portions of the ciliary muscle, the term "cribriform ligament of the ciliary muscle" was much more appropriate. This ligament showed a most marked histological difference in its structure and nature at different periods of life. In youth it was cellular, while as age progressed it became more and more fibrosed. It was this physiological sclerosis in excess that he considered was the fundamental *causa causans* of primary glaucoma, in the causation of which two factors must be separated—the one constant, the other accessory.

The first and constant factor was sclerosis of the filtration network and a consequent diminished outlet.

The second and variable agent was vaso-motor in nature, and it was this which determined the acute attack, in which there was super-added to the first an inflow out of proportion to the available and already reduced channels of exit from the eyeball. Viewed in this light, all the phenomena of glaucoma, clinical and pathological, could be explained.

A closer study of this sclerosis of this filtration network gave a clear view of the process of development, and stages of formation of connective tissue, with definite histological proof that white and elastic tissue was not a direct conversion of the cell protoplasm, but was derived indirectly from alteration and transformation of a homogeneous substance which was itself the product of cellular activity. The alveoli of the filtration network were connected with the lymph spaces of the cornea and sclera, whose fixed corpuscles were brought into direct association with the endothelial cells of the anterior chamber. It was in consequence of this anatomical continuity that the cornea, by diffusion, received its nourishment from the aqueous. This fact would explain a great deal, and would have the utmost bearing on the pathology of corneal diseases.

A meeting was held in Chester Town Hall on November 12th for the purpose of promoting a memorial to the late Dr. Everett Dutton, of Chester, in connection with the Tropical School of the University of Liverpool. Dr. Dutton, it will be remembered, died in the interior of Africa some time ago while investigating the cause of sleeping sickness.

PUBIOTOMY. (a)

WITH NOTES OF AN ILLUSTRATIVE CASE.

By THOMAS WILSON, M.D.Lond., F.R.C.S.Eng.,
Obstetric Officer to the General Hospital, Birmingham, and to the In-Patients at the Maternity Hospital.

In the intermediate degrees of pelvic contraction, when the conjugate diameter measures between 2¾ and 3½ inches, efforts have continually been made, at least since the middle of the eighteenth century, to devise a method of securing a living child without at the same time increasing the risks of the mother. These efforts have taken two directions—to enlarge the bony circle of the pelvis on the one hand, and, on the other, to procure a smaller child. When the patient is seen early in pregnancy, the latter object is sought to be attained by the induction of premature labour, which was first introduced as an obstetrical procedure in this country, where it was performed successfully by Macauley in 1756, and has ever since been regarded with peculiar favour.

The results of induction of labour in cases of contracted pelvis have been gratifying so far as the mother is concerned. Sarwey (Winckel's *Handbuch der Geburtshülfe*, Bd. 3, Tl. 1), in a collection of 2,200 cases in the 15 years from 1890 to 1904, found a maternal mortality of 32, equal to 1.4 per cent., 13 of the women having died of puerperal infection. As regards the child, the results are, as might be expected, much less satisfactory. In the same series of cases Sarwey found that 21.8 per cent. of the children were born dead, and another 15.5 per cent. died before the mothers were discharged from hospital, so that only 1,380 children, equal to 62.7 per cent. of the whole, were discharged living. The risks of the first year of life are greater in premature infants than in those born at full term, and on this point Sarwey inquired into the fate of 500 children in his collection who were discharged living from 12 different institutions. Of these, 406, equal to 81.2 per cent., were alive at the end of the first year. I have quoted these figures because they are the most favourable large statistics of the results of induction of premature labour that I have been able to find. It follows from them that not more than 50 per cent. of the children obtained by this operation are alive at the end of the first year, a result that calls for grave consideration, more especially at a time when the birth-rate in these islands shows a continuous and somewhat rapid diminution.

In cases where premature labour is indicated, and where craniotomy has often to be performed, a safe and not too difficult method of widening the bony pelvis has long been sought. For this purpose, division of the pubic symphysis was first recommended in France in 1768 by Sigault, who put the operation to a practical test in 1777. His patient had a rickety pelvis with a true conjugate diameter of 6.5 cm., and had previously borne four dead children. Two months after the operation the patient walked with considerable difficulty, and had a urinary fistula, which never healed. In the following two years 8 cases were made known, with the deaths of 4 of the mothers and 7 of the children. After such experiences symphysiotomy fell into disrepute until the latter part of last century, when it began to be recommended again by Morisani in Naples in 1866 and Pinard in Paris in 1892.

In the five years 1887 to 1892, Morisani operated on 55 cases, with 2 deaths of mothers, equal to 3.6 per cent., and 4 deaths of children, equal to 7.3 per cent. Pinard, in 1892 to 1894, performed 49 symphysiotomies, with 2 deaths of mothers and 5 of infants. Zweifel until 1899 had done the operation 35 times without a maternal death; then in 11 weeks he lost 3 mothers. His total maternal mortality was thus 6.5 per cent., while 4 of the children, equal to 8.7 per cent., died.

In this country symphysiotomy has never been regarded with general favour, and the only paper on the subject of any practical importance is one by Herman in the *Obstetrical Transactions* for 1901, Vol. XLII., p. 282, in which the author describes the subcutaneous method of performing the operation. A sharp tenotomy knife, having a blade an inch long, and one-eighth of an inch in diameter, is inserted opposite the middle of the symphysis pubis, and the joint is divided by cutting first down, then up. The advantages claimed for this method are simplicity, quickness, small risk of sepsis, insignificant hæmorrhage, absence of a gaping wound, and of subsequent scar. The only risk at present inseparable from the operation is considered to be that of injury to the urethra, which is likely to happen in excessive separation of the pubic bones in cases in which an attempt is made to deliver by symphysiotomy too large a child. In Herman's paper three cases are described, and four others referred to, as having been performed with good results in the London Hospital.

(a) Read before the Gynæcological and Obstetric Section of the Royal Medical Society, Thursday, November 14th, 1907.

The apparent simplicity of the operation is attractive, but on attentive consideration it appears that in the immediate neighbourhood of the part chosen for division are many structures which it is very desirable to avoid. The clitoris and its corpora cavernosa can hardly escape injury, and may be the sources of severe hæmorrhage difficult to control. Behind the symphysis is a large and important plexus of veins, while the bladder and urethra are in imminent danger of being crushed during the delivery of the child, or torn by the separation of the bones. In practice the operation has by no means proved to be an easy one, and its difficulties and dangers have resulted in its being rarely practised in this country.

In the last few years an attempt has been made, more particularly in Italy and Germany, to establish another operation for widening the bony pelvis by dividing the pubic bone instead of the symphysis. This procedure appears first to have been recommended by Champion de Bar le Duc and Stoltz at the beginning of the nineteenth century. According to Zweifel (*Zentralblatt für Gynäk.*, 1906, p. 1), Galbiati operated in 1832 by sawing through the pubic bone on one side, and in 1841 by sawing through the pubes on both sides, but the results do not appear to have justified an extensive use of the operation. In 1893 Gigli recommended that the pubes should be divided by means of his saw, which resembles a length of piano wire, but the operation was not actually employed on the living subject until five years later, when, in 1898, Bonardi employed it for the delivery of a IV.-para with a simple flat pelvis who had already had several difficult labours. Bonardi was soon followed by Calderini of Bologna, and Van de Velde in Haarlem, and then the operation rapidly became popular in Germany, where it has been specially practised by Döderlein, Leopold, Fritsch, Baumm, and Olshausen. In the last four years considerably more than 200 cases have been reported, and almost an equal number of papers and references have appeared, especially in the *Zentralblatt für Gynäkologie* (*a*).

Two methods of performing the operation have been devised—the open and the subcutaneous. In the former a free incision is made down to the pubic bone, which is then divided by the wire saw. This method has many disadvantages, among which the dangers of excessive hæmorrhage and of wound infection are the chief. These dangers are avoided by the subcutaneous method, which is named after Döderlein, and is now almost universally preferred. In this method the patient is placed upon the back with the knees bent, and the thighs abducted and slightly flexed. A small vertical incision three quarters of an inch in length is made straight down upon the pubic spine; a large, specially constructed curved needle is then carried down behind the pubes, care being taken to keep the point of the needle in close contact with the surface of the bone. The point is made to emerge at the outer side of the labium majus, the wire saw is attached, and the needle withdrawn. The bone is then divided in a line nearly parallel to, and at a distance of half an inch from, the symphysis. As the bone is divided there is some bleeding, usually moderate in amount, but occasionally profuse; in the latter case pressure for a short time suffices to stop the loss. The child is then delivered by the method that appears best, the position of the legs being varied according to circumstances. Afterwards the upper wound is closed by one or two sutures, and the lower wound is also closed, or in some cases drained by a narrow strip of iodoform gauze. The pelvis is supported by a sandbag on either side, or by a broad strip of strapping across the front, or by an elastic bandage. The patient in most cases can get up without pain or discomfort on the sixteenth or eighteenth day.

This short description of the operation requires to be amplified in several important practical directions. The side chosen for the incision in vertex presentations is usually that on which the occiput lies, unless there is some contra-indication, such as varicose veins or hernia on that side. If the bladder is clearly on one side, the incision should be made on the other. Van Cauwenberghe claims that his observations on the cadaver show that widening is greater on the divided side, and in unequally contracted pelvis he recommends, therefore, that the cut should be made on the smaller side. The method of passing the needle varies with different operators. Usually this is done from above down, but Walcher and other operators pass the needle from below up, a method recommended by Tandler as the result of his anatomical researches The main source of bleeding in pubiotomy is injury to the crus of the corpus cavernosum on the side of the division, and by cutting down on the lower border of the pubic ramus, separating the periosteum, and with it the crus from the bone, and then passing the needle from below up, it is thought that injury to the crus may be avoided. Even then, however, there is a risk of the crus being injured by the movements of the saw in dividing the bone, and as the bleeding is usually moderate and easily controlled by pressure, the little additional complication appears to be unnecessary.

In the method of delivery the greatest variation has appeared. That which has been chiefly employed is extraction by forceps, though many operators have preferred version. Recently there has been an increasing tendency, after dividing the bone, to leave the labour to the natural efforts. This was first recommended by Zweifel, and tried by Döderlein, and it is claimed that it offers less danger to the maternal soft parts, and at the same time gives a better chance to the child. On the other hand, it has been suggested that it increases the liability to the formation of a hæmatoma. The position of the patient's legs at the different stages of the operation requires careful attention, and will be considered in connection with the description of the changes produced in the pelvic cavity by the operation.

The dangers of the operation include, in the first place, bleeding, which has rarely been so copious as to call for opening up of the wound and the application of ligatures; generally the hæmorrhage is moderate in amount, and easily controlled by pressure. A slight degree of hæmaturia has been observed in a considerable proportion of cases, and appears usually to be caused by bruising of the wall of the bladder against the cut edges of the bone. In one case reported by Baumm the bladder was ruptured; in no case have I seen mention of injury to the urethra. Commonly in the hours after delivery a hæmatoma forms at the site of operation, but usually this remains small, and becomes absorbed without giving rise to trouble in the course of a week or ten days. Œdema of the vulva is commonly present in the first two or three days.

Œdema of the leg from thrombosis of veins has been several times described, sometimes on the same side as the division, and sometimes on the opposite. The risk of infection in cases that are placed under satisfactory conditions from the commencement of labour appears to be slight, and where the operation has been performed in cases of pre-existing infection the results have been on the whole satisfactory, as shown in cases reported by Schauta, Sitzenfrey, Arndt,

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(*a*) In this country Berry Hart (Edin. Obst. Trans., 1903-04, vol. xxix.) was the first to try the operation, which has received the various names of pubotomy or pubiotomy, lateral section of the pelvis (Gigli), hebotomy (Van de Velde), and pubosteotomy. In Hart's case the operation was quite successful in effecting delivery, but the patient died of late chloroform poisoning. The case on which this communication is founded was the second to be performed here. In the May number of the "Journal of Obstetrics for the British Empire" for this year papers appear by Gibson and Hastings Tweedy, each of whom has performed the operation with success three times. In Tweedy's first case there were great difficulties and alarming complications, but the conjugate diameter measured only slightly more than 2½in. The total number of pubiotomies so far done in these Islands appears to be eight, all the children being born alive, and one mother dying from the results of anæsthesia.

and others. It has been suggested by Von Franqué that the operation can be done by hands which do not touch the genitals, and so can be carried out with reasonable safety in patients already infected. The principal danger arising out of the operation is that of laceration of the vagina, by which the subcutaneous division of the bone is converted into a dangerous compound fracture. This accident appears to be fairly common, especially in patients with narrow vagina and small vulva, and in such cases it appears better to make a deep perineo-vaginal incision on the side diagonally opposite to the division of the pubic bone. In every case the vagina should be carefully examined after delivery is completed, and if there is any laceration this should be treated by careful suturing, with provision for drainage. By these means it is possible either to prevent laceration taking place or to secure favourable union.

The results of the operation as regards both mother and infant have been excellent. The patient is able to get up on the fourteenth to the sixteenth day, and in a large proportion of cases to be sent home on the twentieth day. There is no difficulty or pain in walking. Union of the bones takes place first by formation of fibrous tissue, and later by bone. A considerable amount of callus is thrown out on the anterior surface of the bone, but it appears to be the rule, and certainly occurred in my case, that only an extremely small quantity is thrown out on the inner surface of the bone, an important observation from the point of view of subsequent labours. In cases where pregnancy supervenes soon after the operation, it has appeared in several cases that bony union is delayed for many months, and it has been claimed, though without sufficient evidence, by some observers, that a permanent widening of the bony pelvis takes place.

The following are the notes of my case:—

R. J., æt. 30, was admitted to the Birmingham General Hospital on October 23rd, 1905, for the eighth labour, which was estimated to be due on the 29th. The first four labours were terminated by forceps, all the children being born alive, the first and third still surviving. The fourth labour was attended by Mr. N. H. Turner, who recommended that the next should be induced at the eighth month.

I had first seen the patient in her fifth labour at term on September 28th, 1901. The labour was obstructed. On my arrival the vulva and anterior lip of the cervix were œdematous, the child was presenting in the left occipito-anterior position, the head more in the right side of the pelvis. By forceps an average sized male child was delivered, with an extremely moulded head, a deep groove on the left parietal bone parallel to the coronal suture, and facial paralysis due to pressure of the end of one blade of the forceps. The facial paralysis disappeared in a fortnight, and the child lived for 3¾ years. The pelvis was reniform, the sacral promontory forming a considerable projection into the brim. The external pelvic measurements were:—

Dist. sp. il., 25. cm.
Dist. cr. il., 27.5 cm.
Ext. conj., 18.75 cm.
Diag. conj., 11.5 cm.

The patient said she had been delicate as a child, was late in learning to walk, and had to work hard from her early girlhood.

The sixth labour was induced three weeks before term by hot injections and bougie on December 17th, 1902. Fifty hours after the introduction of the bougie a well-developed male child was delivered under chloroform by bi-polar version, with forceps to the after-coming head. The child was with difficulty revived, and died the same evening. The seventh labour was induced at seven and three-quarter months on September 3rd, 1904. Forty-five hours after the introduction of a bougie a female child 4¼ lbs. in weight and 17½ ins. long was easily delivered by forceps. It died the next day.

On the present admission the patient was said to have last menstruated on January 25th. Labour pains began on the evening of November 21st, 1905, and at 3 p.m. on the 22nd the cervix was fully dilatable. The child lay with its back to the right, the head freely movable above the brim; the fœtal heart, 150 to the minute, was heard far back on the right side. About three pints of liquor amnii escaped when the membranes were ruptured. In spite of strong pains, the head, which entered into the third vertex presentation, failed to engage firmly.

Operation.—The patient was anæsthetised, and forceps applied. Forcible traction was then made at intervals of three minutes, but entirely failed to bring the head through the brim. Pubiotomy was determined upon, and was carried out by the modified subcutaneous method. A vertical incision 1¼ inches in length was made upwards from the pubic spine on the left side. The incision was carried down to the bone, and a Gigli's saw was then, by means of a Seeligmann's director, passed downwards close to the posterior surface of the left pubic bone, and brought out at a point on the outer side of the left labium majus. The bone was easily sawn through, and the divided ends immediately sprang apart, leaving a gap of ¾ inch or thereabouts. The upper end of the division was a little internal to the pubic spine. The forceps were again applied, and the child very easily delivered, the occiput coming forward into the second vertex presentation at the outlet. Ergot was now administered subcutaneously; the placenta was expressed from the vagina after 15 minutes. The upper incision was closed by silkworm gut sutures; the lower small one had ragged edges from the action of the saw; it was partly closed by one suture and drained by a small strip of iodoform gauze. A broad strip of adhesive plaster was brought across the front of the pelvis from side to side. The child weighed 8 lbs., and soon began to cry vigorously.

Result.—The subsequent course of the puerperium was normal in every respect. There was moderate œdema of the left labium majus, which gradually disappeared in seven days. The upper wound united by first intention, and the lower one was firmly healed by the end of the second week. On the twelfth day after operation a thick callus was felt along the line of division on the outer aspect of the bone; on the inside the division felt like a slight depression, and there was no exudation making prominence above the surface.

At the end of the third week the patient was allowed to sit up, which she did quite comfortably. Two days later she was radiographed, a clear space about ¼ inch wide showing between the divided portions of bone. During my absence from hospital for a few days, my Resident interpreted this clear line to mean that no union had taken place; he therefore ordered the patient back to bed. As a consequence, when I next saw the woman she had developed a well-marked neuromimetic paralysis of the left leg. Every movement of the limb, including abduction, adduction, and rotation of the thigh, could be performed perfectly by the woman as she lay in bed; but when asked to stand she collapsed, and would have fallen to the right, the left leg at the same time becoming extended and rigid. There was no affection of sensation, the limb remained normal in nutrition and appearance, and there were no alterations in the deep or superficial reflexes. Electricity, massage, and the exercise of patience were followed in a few weeks by the return of normal power in the limb. The patient has had no further pregnancy, but has remained well and able comfortably to carry on all her household work. The child died at the age of 1½ years from some wasting disease.

The operation, in my opinion, is a good one, appearing to possess the advantages claimed for symphysiotomy, while avoiding some of its more serious disadvantages. The wounds are small, and placed well away from the vaginal orifice; the divided bone readily unites, first by fibrous and later by osseous tissue. The situation of the division on one side of the middle line greatly lessens the risk of injury to important structures. The only likely source of hæmorrhage is the crus of the corpus cavernosum, which is usually divided at the same time as the bone is sawn through; pressure for a short time suffices to stop the bleeding. The relations of the wound in the bone to the clitoris, the bladder, and more particularly to the urethra, are much less close than in symphysiotomy, and thus the particular dangers of the latter operation are obviated.

With the same degree of separation of the bones, the amount of widening of the pelvis, according to comparative observations made on the cadaver by Sellheim, is the same after pubiotomy as after symphysiotomy, but after the former operation the separation requires three times greater force than after symphysiotomy. The divided ends of the bone are held in contact by the attachments of the adductor muscles, and only separate to an extent sufficient to allow the passage of the child. The sudden springing apart, which has occasionally been attended by serious injuries to the soft parts in symphysiotomy, is not likely to occur here. The limit of safe separation of the divided bones appears to be about 6 cm., any further widening being likely to cause rupture of the sacro-iliac joints. Morisani said that after symphysiotomy with a separation of 6 cm., the conjugate diameter is increased by 13 to 15 mm., and that the bulging of the soft parts increases the enlargement to about 22 mm. Döderlein says that in this amount of separation the superficial area of the brim is increased by about half, from 105 to 155 square cm.

As the bones become separated the inclination of the pelvis is increased (Ahlfeld), while the cavity becomes funnel-shaped and at the same time shallower from above down, the last effect depending upon the raising and flattening of the pelvic floor by the unyielding sacro-sciatic ligaments. Kroemer draws special attention to the effect upon the separation of the bones produced by alteration in the position of the legs.

The indications for the employment of pubiotomy are the same as those for symphysiotomy. The pelvis must not be anchylosed, and must have a conjugate diameter of not less than 2¾ inches in a flat and not less than 3 inches in a generally contracted pelvis; below these limits Cæsarean section is a safer and better operation. If there is a probability that the patient is already infected, craniotomy will usually be preferable. Auscultation must afford proof that the child is living and strong. Labour must have advanced so far that the cervix is fully dilated or fully dilatable, or dilatation should have been completed by the hydrostatic bag; sufficient time must be allowed for the natural efforts to mould the head. If, then, in spite of strong pains, no progress is made in two hours in a multipara, or four hours in a first labour, or if the maternal pulse rises so that it remains at 100 in the intervals between the pains, delivery should be attempted by the high forceps operation under chloroform. The attempt should not be prolonged or repeated, but immediate recourse had to pubiotomy.

DEATH FROM HÆMORRHAGE FROM A MEDICO-LEGAL POINT OF VIEW.

Part III.

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(Specially reported by our German Correspondent.)

Concluded from page 521.

Fatal hæmorrhage in the new-born occurs first from not ligaturing the umbilical cord.

Although omission to tie the cord occurs more frequently in precipitate labour, in concealment of birth, infanticide, and exposure, yet in these cases death from the omission is only rare, as under normal circumstances, after separation of the placenta, the umbilical arteries contract, the intima doubles on itself, thrombi form, and the blood pressure falls in consequence of the development of the lesser circulation. For this reason fatal hæmorrhage from the unligatured umbilical cord was formerly denied. On the other hand, others considered that death always followed when the tying was omitted. For an explanation of these contradictory views we must assume that for the occurrence of this fatal hæmorrhage special abnormal pathological and physiological conditions are necessary, although, from the small number of cases that occur, no sufficient proof of this has been established. These causes may be (Beckert) (54) an abnormal condition of the vessels of the cord, unusual thinness and softness, abnormal course, increased blood pressure when the lesser circulation does not become established or only imperfectly so, or hæmophilia.

Besides this, the following are to be considered as favouring factors (Caspar-Liman): When the cord is cut very close, although fatal hæmorrhage may occur when it is cut long (as case 448 of Caspar-Liman shows); further, when the division is effected by tearing and not by cutting; also when the cord is gelatinous and soft, as in such a case the ligature may become loose and fall off from the cord drying in. The diagnosis of fatal hæmorrhage from the umbilical cord is based on the general anæmic condition of the organs, anæmia from wasting being excluded; secondly, signs of bleeding having taken place, which may, however, have disappeared; thirdly, division of the cord between the umbilicus and the placenta, and, fourthly, exclusion of all other causes of death. From the fact that the cord has been tied or left untied, no proof can be drawn either for or against fatal hæmorrhage, as a ligature can be applied after death, and, on the other hand, one applied during life may have become loose and fallen off, or it may have been tied firmly and bleeding still have taken place. Caspar-Liman mention three cases (Nos. 449, 450, 451) in which fatal hæmorrhage took place in spite of a long cord and firm tying. Finally, the diagnosis will be much strengthened by proof of the pathological or physiological abnormalities already mentioned.

In a case mentioned by Ahlfeld (56), the cord, which was very thin and poor, was torn by the midwife 3 cm. from the umbilicus, and the child died from fatal hæmorrhage. On the right arm of the child was a furrow as from a ligature, which showed that a good deal of pulling had taken place. This rare case shows at the same time that caution should be used in condemning a midwife. Beckert (54) (Zeitschr. f. Med. Beamte, 1889, S. 569) quotes two cases by Haberda and Brouardel in which intra-meningeal hæmorrhage prevented the establishment of the pulmonary circulation, and rendered possible fatal hæmorrhage from the cord. Hæmophilia cannot be recognised on the cadaver, but only through heredity being proved.

The experiments of Caspar-Liman and Hofmann on the tearing-point of the cord, made by hanging on heavy weights of 500 to 1,000 grm., are of no practical value, as they are too little imitated on the living subject. We should not therefore conclude, when the cord is torn in a case of precipitate labour, that no blame attaches to the mother. It seems remarkable that no experiments have been made on the dead body to solve the question whether when the cord is firmly tied as the midwife is instructed to do it it can so far shrink and loosen that fatal hæmorrhage can take place. The elucidation of the question of blame in cases of fatal hæmorrhage from the umbilical cord is of special importance from a medico-legal point of view, and sometimes very difficult. The medical witness may be asked: Is the omission on the part of the mother to tie the cord from ignorance or from design, or in consequence of thoughtless want of preparation for her confinement? Secondly, in case the cord has been tied and has become loose, so that fatal hæmorrhage has taken place, has the midwife been guilty of causing death by criminal negligence, or of proceedings against the security of life? Views on these points are divided. Hofmann (1) states with emphasis that proof that omission to tie the cord has been intentional cannot be established, as we cannot prove that primaparæ, who are chiefly concerned, have any knowledge of this manipulation. Caspar-Liman take the view that in a case of the loosening of a cord that has been tied, the midwife should not be blamed without further information. Here an opinion would be arrived at from the surrounding circumstances as to intention or not. Thus Dittrich (55) (Aerz. Sachverst.-Zeit., 1897, 43 and 44) mentions a case of fatal hæmorrhage from the cord in which from the circumstances design could be excluded: A girl was going to the hospital in company with other people to be confined, when labour took place in the railway carriage; she severed the cord ignorantly, and wrapped several turns of a bandage round the stump. The child died of hæmorrhage. Between the cord and the ligature a thick sound could easily be passed. Beckert, who has recently interested himself with the question of blame in cases of fatal hæmorrhage from the umbilical cord (Zeitsch. f. Med. Beamte, 1899, S. 569), reports a case in which a midwife escaped conviction through difference in opinion amongst the medical witnesses, and as amongst the published cases he has met with only two convictions he is of opinion that the witnesses have been too lenient, being afraid of the consequences that might follow a conviction. He would have a charge made in every case in fatal hæmorrhage from the ligatured cord; the midwife has a great responsibility, as such hæmorrhages can be avoided in every case by careful and conscientious tying of the cord. In any case the question of blame where fatal hæmorrhage takes place when the cord has been tied has not yet been satisfactorily settled.

A child may also bleed to death from the cord during birth in cases of insertio velamentosa, when the advancing part of the child lacerates the velamentum. Volland (53) has collected 15 such cases from literature. Death may also take place from tearing of the cord when it is too short. Further, when there is a common placenta, a twin may bleed to death after the birth of the first one if its cord is not tied doubly (Sachs).

Besides death from bleeding from the cord, fatal hæmorrhage may also take place from injuries and ruptures occurring during labour, whether intentional or unintentional, along with proper or improper expert assistance, and whether the organs are healthy or diseased. To this category belong: Fatal hæmorrhage from tearing out of limbs, perforation, morcellement, rupture of blood vessels (particularly cerebral hæmorrhages), rupture of organs (the liver, spleen, intestines), fatal bleeding from parenchymatous organs.

It is to be noted that bruises and ecchymoses appear on the tumours of the head, buttocks, and shoulder, but they do not fall under this category. As consequences of obstetric operations, ruptures of the liver and spleen, for example, have been observed. Körber (St. Petersb. med. Wochenschr., 1892, No. 51) relates a case in which rupture of the liver occurred as a result of swinging the child in the way recommended by Schultze in cases of suspended animation. The question of blame in cases of rupture of organs is frequently very difficult from a medico-legal point of view. It has to be ascertained (Geill) whether the ruptures of organs found after death really took place during birth—*i.e.*, whether they were produced during spontaneous labour, under special circumstances (lingering labour from irregular presentation, contracted pelvis, rigidity of the soft parts), by assistance given by the mother herself, by the obstetrician in attempts to restore animation in a child apparently stillborn, by ignorant treatment of a child born alive (rupture of bowel by enemata), by infanticide, spontaneous rupture (of the spleen), by improper management of the stillborn child, or by any other cause. Dittrich (57) is of opinion that as manipulations that are to be looked upon as proper are carried out in normal labour also, it may be properly assumed that ruptures of internal organs may occur during labour, in which all mechanical violence independent of that of the maternal organism can be excluded. Kratter (71) concedes this as regards ruptures of organs, but not for hæmatomata of internal organs. In my opinion it appears certain that every case must be examined as to whether the force employed by the obstetrician or the midwife was necessary, or whether it was more than was allowable. Fatal hæmorrhage from ritual circumcision in cases of hemophilia is to be mentioned.

Fatal hæmorrhage from the female genital parts occurs from solution of continuity in the region of the clitoris, from wounds of the vagina from coitus, from wounds of the uterus during pregnancy, and in connection with labour. Cases of fatal hæmorrhage from the region of the clitoris, in which parenchymatous bleeding from the corpora cavernosa clitoridis may be fatal, as already mentioned, are rare. Niemann (Henke's Zeitsch., Bd. 392, S. 310, quoted from Hofmann) reports the intentional killing of a woman by a cut in the external genital parts.

More frequent, and more difficult to decide from a medico-legal point of view, are fatal hæmorrhages from wounds of the vagina from coitus. From statistics collected by Neugebauer (Monatschr. f. Geburtshilfe u. Gyn., 1899, IX., S. 22, iu. 289), out of 157 observations, there were 22 cases of fatal hæmorrhage. As to whether the wounds were produced simply by manipulations during coitus, opinions differed. Caspar-Liman's collection shows only cases in which the injuries were caused by the introduction of the finger or instruments. Maschka denies the occurrence from coitus, and explains five cases of wounding the vagina by the forcible use of the fingers. Hofmann concedes the possibility of such an occurrence, and attributes it to the brutality of the man, and want of proportion between the man's penis and the vagina. Mennicke (62), from his own observations, comes to the conclusion that the possibility of lacerations of the vagina occurring sub coitu cannot be completely excluded, as they were formerly, when some of the following predisposing causes are present: Drunkenness and the use of brutal force on the part of the man, a peculiar position during the act, want of proportion between the size of the penis and that of the vagina (for example, attempted rape of little girls); on the part of the female, status infantilis of the genital parts, climacteric age, antecedent gynæcological operations (colporrhaphy operations on the perineum). Mennicke relates a case in which the hostess of an inn, aged 55, died suddenly in the night, although she had been quite well the evening before; the husband had the reputation of being brutal and of leading a loose life. The autopsy revealed laceration of the vagina, and death from hæmorrhage. The medico-legal opinion agreed with the superior opinion of a professor, that the laceration might have been produced by coitus, and consequently not necessarily by another injury which was not excluded. Wichmann (63) (Aerztl. Sachverst. Zeit., 1900, No. 4, S. 67), reports on a case of laceration of the vagina, with subsequent fatal hæmorrhage from intercourse with a factory girl who was in the ninth month of pregnancy, and after inquiry into the case, comes to the same conclusion as Mennicke. Warmann (66) (Zur ætiologie u. forens. Bedeutungder Scheidenruptur, Zentralbl. f. Chirurgie, No. 24, 1897) finds the cause of rupture of the vagina, not in the disproportion between the size of the penis and that of the vagina, nor in too little power of resistance, nor in the altogether too stormy intercourse on the part of the man alone, but too much vigour on the woman's part, and maintains that when the woman strives against the act, rupture of the posterior wall of the vagina is impossible; such ruptures are not consistent with rape.

In my opinion deaths of this kind must from a medico-legal point of view be judged individually, not only as regards the autopsy, but taking in all the accompanying circumstances (see Mennicke's case); no general rule can be laid down concerning them.

Fatal hæmorrhage may also take place from rupture of the fœtal sac in ectopic gestation. The rupture is spontaneous as a physiological necessity, or from injury, which may be only very slight, as the fœtal sac has but little resisting power. These cases are of importance forensically, when an injury that might be the cause of the rupture has preceded it, whether the rupture is spontaneous or not. It is naturally difficult to arrive at a decision.

During labour fatal hæmorrhage may take place from wounds of the genital passages—ostium vaginæ (especially the region of the clitoris), vagina, uterus (cervix and fundus)—which may be caused naturally from want of proportion between the fœtus and the maternal parts, or from medical assistance being omitted or improperly rendered (Sachs). Here it has to be determined forensically whether the person responsible for the course of the labour (physician or midwife) had rendered the assistance demanded in a skilful manner, and kept the patient sufficiently long under observation after the completion of labour, whether she has been left too soon, and that whether thereby the aid that was demanded could not be rendered.

Fatal hæmorrhage from rupture of the uterus is of special importance. According to Schroeder, rupture of the uterus occurs during pregnancy from the third month on, later on more frequently, but upon the whole very rarely from any considerable crushing. Any force acting from before backwards against the vertebral column is more likely to be followed by rupture than one acting from the side; spontaneous ruptures during pregnancy are very rare. It must be assumed that some congenital or acquired thinness or softness of the uterine walls (Cæsarean section in a previous pregnancy, or softening from inflammation) is necessary for a rupture to take place. Rupture can then take place from slight causes, lifting a weight, a jump, a push, a fall, a cough, vomiting, or any other strain of the abdominal walls, or even without any apparent cause. The point of rupture—in contrast to those occurring in partu—is regularly in the fundus or at least in the adjacent parts (Schroeder). Jellinghaus (68) (Archiv. f. Gynækol., Bd. 54, H. 1) relates a case of rupture from thinning of the muscular walls. Ruptures of the uterus may occur spontaneously during labour, or they may be favoured by the pathological conditions mentioned, if when any hindrance to the passage of the child occurs—abnormal presentation, normal presentation, but contracted pelvis, hydrocephalic head of the child, and the lower segment of the uterus is over stretched, so that it tears; after such an event fatal hæmorrhage frequently takes place.

Such cases may become the subject of medico-legal inquiry if improper methods of treatment have been taken by the medical attendant or midwife, introducing the hand too far in, for instance, and thus contributing to the rupture. It will mostly be very difficult to decide whether a rupture has been unavoidable and would have taken place from the pains alone, or whether the fault lay with the medical attendant. Here also the circumstances may prove of value in arriving at a decision. In my earlier years of practical work I was called to the assistance of a colleague in a difficult case of labour. As I made my appearance the patient had just died, whilst the surgeon was rendering assistance in a case of rupture of the uterus and subsequent fatal hæmorrhage. No medico-legal inquiry took place, as the known good position of the medical man in question excluded any question of incompetence. The discovery of a morbid condition of the uterine muscles makes the diagnosis more simple. Heydrich (70) (Centralbl. f. Gynækol., 1897, No. 20) reports on a rare case, important from a medico-legal point of view, in which a very pendulous abdomen was the cause of the rupture, in consequence of which the posterior wall of the uterus was greatly stretched and rubbed through by the advancing head. Much more can be done from a medico-legal point of view in those numerous cases in which death results from injuries of the female genital organs that have been brought about by too rough or careless handling, or those fatal accidents when the treatment on the part of the persons responsible has been quite correct (v. Sachs).

Medico-legal records of errors in the performance of obstetric operations by surgeons, midwives, and quacks are very numerous. Penetration of the vagina and uterus by instruments are the most frequent occurrences. Injuries of the bowels in connection with rupture of the uterus also occur. As a curiosity a case quoted in the "Vierteljahrsch. f. gerichtl. Med., Bd. 21, S. 80, may be mentioned, in which the whole uterus was torn away in removing the placenta. In these cases, mostly of grave injury caused by violent manipulations, fatal hæmorrhage is frequent. The question of blame is usually not difficult to decide. After labour fatal hæmorrhage may occur from atony of the uterus, and it may be the subject of medico-legal inquiry if the woman confined has been left too soon after delivery, or if it can be proved that the person responsible failed to make use of the usual internal remedies or manipulations, although it must be remarked that death may follow in spite of their employment. Secondly, if the placenta has been separated by the hand and a portion left behind, proof of blame in such cases is not difficult to establish. Thus Mair (85) mentions a case of fatal hæmorrhage from atony of the uterus, where the midwife removed the after-birth without satisfying herself that the uterus had contracted. The blame might easily have been fixed upon her in such a case.

The Relation of Death from Hæmorrhage to the Accident Insurance Law and to the Civil Code.

The forensic surgeon may be placed in a position in which, in cases of death from hæmorrhages of persons who are insured against accidents, of having to decide whether the death has been caused by the accident whilst at work, or whether it has been spontaneous as the natural outcome of an illness. On this decision hangs the right of the heirs to the insurance moneys; further, whether the death in question was connected causally with an earlier accident or an earlier injury or not. The right to compensation for injury on the part of survivors, according to par. 844 of the Civil Code, may hang on this decision. The cases belonging to this class are not numerous, so that there is a scarcity of material for reference. In general these questions are difficult to decide. In an earlier place a case reported by Danzer has already been mentioned (28), where proof could not be adduced that death was due to an accident that occurred seven years before. But even when it is only a matter of days between the injury and death, it is not always possible to establish the connection. In Friedrich, s. Blättern of 1852, a case is reported where a woman in stealing wood was struck with a stick. Four days afterwards she died from hæmorrhage from an aneurysm (it was probably an aneurysm of the aorta, but this is not shown in the proceedings). The connection between the injury and the death could only be established as probable. In the Aerztlich. Sachverständ. Zeit., 1898, No. 8, S. 167, a case is mentioned of sudden death from bleeding from a gastric ulcer whilst at work, in which the trade society objected to pay the claims on the ground that the death was the natural outcome of an advanced degree of disease of the stomach. In a trial, however, they were held liable on the ground that on the day on which the deceased met her death the work was particularly heavy, that this caused unusual action of the heart, and that the hæmorrhage was due to that. In another place (77) a case of hæmorrhage from the lungs is mentioned that occurred four days after an accident in a man who was suffering from intestinal tubercle, the deceased striking his right side against a wooden corner in falling into a filter pit. The connection between the accident and the death in this case was confirmed by the medico-legal expert, although denied by the medical officer to the man's trade society, and the money claimed was paid. In another case (76) the connection between fatal hæmorrhage from the lungs and the performance of work—lifting a heavy chest—was denied for want of sufficient evidence that it was due to any one distinct act. Markwald (74) mentions the following case: A joiner whilst at work, sawing a beam, was taken suddenly ill with violent pain, vomiting, spitting of blood, inability to move or speak, and died in a few hours. Three minutes before commencing to saw he had lifted a heavy beam. The autopsy showed arteriosclerotic changes in the aorta, free hæmorrhage, an aneurysm that by eating through the bronchial vein had allowed the passage of blood into the bronchus. Markwald denied any connection between the bleeding and the sawing, as there was no proof that this, the proper work of the joiner, was the cause of the bleeding. He gave a warning against a too wide-reaching humanitarianism, and demanded only a searching, scientific criticism of the cases and opinions, lest at a not distant date every disease should be looked on as the result of an accident. From this small number of examples it will be seen that no general principles can be laid down for the treatment of these questions; each case must be decided by itself.

The results of this work may be summed up in the following conclusions:—

(1) The usual course of death from hæmorrhage is this: that immediately on the occurrence of a spontaneous or traumatic solution of continuity of the vascular system internal or external hæmorrhage takes place, and, hindered by nothing, continues uninterruptedly until in a few minutes death takes place from cerebral anæmia.

(2) The principal deviations from the usual course are: interruptions in the course of the bleeding (death

from secondary hæmorrhage, late hæmorrhage), as well as complications through the secondary effects of the bleeding (pressure on the brain, heart, lungs, blocking of the air passages, air embolism).

(3) The deviations from the usual course in the various injuries that may be followed by fatal hæmorrhage show themselves in the following manner:—

(*a*) In fatal hæmorrhages from wounds of the heart all the deviations mentioned may occur.

(*b*) Fatal hæmorrhage from injuries of the great blood vessels deviate from the usual course in proportion to the smallness of diameter of the vessel injured.

(*c*) In death from hæmorrhage from rupture of organs, the mode of origin of the rupture was the first point in the medico-legal inquiry whether the rupture was due to traumatism or whether it was the spontaneous result of some disease of the organ, or whether both modes came into consideration, and, if so, in what relation did the trauma stand to the disease.

(4) The diagnosis of death from hæmorrhage is based on the proof of a solution of continuity in the vascular system, of hæmorrhage having taken place, and of a high degree of anæmia of the body generally when not decomposed, the evidence of other causes of death not being discoverable. In these cases the diagnosis is not difficult on post-mortem examination.

(5) If the body is decomposed, or if there is evidence of other causes, the diagnosis is more difficult, and circumstantial evidence must be appealed to.

(6) For the purpose of distinguishing death from hæmorrhage from allied forms—injury of vital organs—it is an advantage to distinguish between simple and complicated deaths from hæmorrhage:—

(*a*) It is simple when due to loss of blood and nothing else.

(*b*) Complicated when death results from the secondary effects of the bleeding (paralysis from pressure on the brain, heart, lungs, blocking of the respiratory passages by blood, air embolism).

Note.—Those cases are allied to complicated death from hæmorrhage where the bleeding is from a body in which there is a deficient supply of oxygen from a morbid condition of the heart or lungs. Here paralysis of the brain and death will come on earlier, so that absence of blood in the organs may not be as complete as under ordinary conditions. Further, hæmorrhage that would do no harm under ordinary circumstances might be fatal (as in abortions, for example). This statement can at present be given as hypothetical, as no practical examples are so far recorded.

(7) Principles regarding the determination of fatal hæmorrhage from the umbilical cord in infants, when it has been tied, but become loose, cannot yet be laid down.

(8) The determination of the origination of injuries of the vagina (*sub coitu*) that lead to fatal hæmorrhages is, for want of agreement amongst inquirers, very difficult, and cannot be reached without a knowledge of the circumstances.

(9) The causal connection between a death from hæmorrhage and an earlier injury or accident when there is a question of compensation on the part of heirs, or of an accident pension, is frequently impossible, especially when a considerable time has elapsed between the injury and death.

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OUT-PATIENTS' ROOM

ROYAL FREE HOSPITAL.

Epithelioma of the Cheek.—New Operation.

By J. Cunning, M.B., F.R.C.S.

Amongst the out-patients was a man, æt. 56, who complained of soreness of the inner side of the cheek, which came on, he said, a fortnight previously. On examination an ulcer was discovered, in extent about the size of a florin, reaching from close to the angle of the mouth backwards to about the second molar tooth. The ulcer was deeply excavated, with irregular raised edges and a nodular base; the whole ulcer and its margins were very hard and not specially tender; there was a dirty, fœtid discharge from it. In the submaxillary region two small hard glands could be felt. The diagnosis, Mr. Cunning said, was the first point to be established. Ulcers of this type were usually epithelioma; the other ulcers which had to be considered were primary sores and dental ulcers. Dental ulcers could be excluded in this case, for they were always in the neighbourhood of a ragged tooth, and were never of a deeply excavated character. A primary sore might look very like an epithelioma, but as the patient's age was an ordinary one for epithelioma, which is a more common disease than primary sore in the mouth, one would be entitled to assume that this is more likely to be an epithelioma than a manifestation of syphilis. The glands under the jaw would be enlarged in either case, so that they could not be looked upon as helping the diagnosis in either way. There were two ways, he remarked, of settling this point: one was by giving mercury, the other by removing a piece for microscopical examination. The latter of the two methods, he thought, was the better, as it involved no delay. With regard to treatment, Mr. Cunning pointed out that, assuming this was an epithelioma, it could be completely removed, as it was quite free from the jaws; it would mean that a large area of the cheek, certainly as much as the palm of the hand, would have to be taken away. This meant that a very wide gap would have to be filled in. The plan he had devised for doing this was to begin by turning up a large flap covering the submaxillary triangle, and removing the submaxillary and salivary glands from this area, before touching the cheek. The cheek would next be excised. Then the flap raised from the submaxillary triangle would be divided at the junction of its posterior and middle thirds; the anterior section of this flap would then be twisted upwards and fixed to the upper edge of the gap in the cheek close to the angle at which the remainder of the lips would be stitched to one another; the posterior third of the flap would next be pulled forwards and upwards, and stitched not only to the remainder of the upper portion of the gap in the cheek, but also to what is now the posterior edge of the twisted-up anterior portion of the flap. It is now found that a very good new cheek has been formed, which can be covered by a beard in a male patient. It finally only remains to cover the bare area in the situation of the submaxillary triangle; this can be done quite easily by under-cutting the skin of the neck, sliding it upwards, and stitching it to the skin at the level of the lower jaw. In a previous case in which this plan of operation devised by Mr. Cunning had been carried out by him, a very large gap had been filled up with surprising ease, and when the patient returned two months after discharge from the hospital, having in the meantime grown a beard, it was almost impossible to tell that an operation had been done, therefore Mr. Cunning now proposed to perform a similar operation on the present patient.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Radical Cure of Hydrocele.—Mr. Willmott Evans operated on a man, æt. 28, who had been admitted for chronic hydrocele. For some five or six years the patient had suffered from a hydrocele of the right side; it had been tapped many times and liquids had been injected in order to affect a cure, but without avail; the fluid had always re-collected. The presence of the hydrocele was troublesome to him, and he was anxious to have a radical cure. When the patient was anæsthetised the surface of the scrotum was well scrubbed with soap and antiseptics. An incision was then made the whole length of the swelling and extending down to the tunica vaginalis; this was laid open, the contents were evacuated, and the greater part of the parietal portion of the tunica was removed; it was somewhat thickened, doubtlessly owing to the previous treatment. The edges of the wound were then brought together with catgut sutures, and a dressing was applied. Mr. Evans said that the question of the best method of treatment depended greatly on the age of the patient: in small children hydrocele was common, but he had never seen a case in a young child in which even tapping was required, for, according to his experience, cases such as these always got well without any form of operation. In the aged tapping was all that it was advisable to do, at least in the majority of cases, for such patients required to be tapped only once or twice a year, and it was surely better in such cases not to run the risk of a radical cure, slight though that risk might be; yet there were cases even amongst the old in which a radical operation was perfectly justifiable, but the patient must be in good general health and young for his years. During the middle period of life it occasionally happened that a single tapping was sufficient to cure a hydrocele, or perhaps the fluid might not re-collect after the second or third tapping; usually, however, it was not possible to cure a hydrocele simply by removing the fluid, and something more was required to be done. In many cases injections of certain liquids after tapping the sac led to a cure. Many liquids have been used for this purpose which are quite discarded now. At one time it was advocated to re-inject the fluid which had been withdrawn; port wine was also a favourite injection. At the present time there are only two liquids which are much used for injection in these cases; one is a weak solution of iodine, the other is carbolic acid. It is important in employing these liquids that the inner opening of the cannula should be definitely within the sac, otherwise the liquid is liable to escape into the loose connective tissue superficial to the tunica vaginalis, setting up a severe and painful, though aseptic, cellulitis. Whatever fluid is employed, the whole of it should be evacuated through the cannula. This method is sometimes successful; its mode of action is by no means certain. The cause of a persistent hydrocele is the excess of secretion of hydrocele fluid over the absorption. This may be produced in either of two ways: the amount secreted may be abnormally great or the power of absorption may be diminished. Even in a perfectly healthy tunica vaginalis fluid is always being secreted and always being absorbed. How the injection acts is not clear. At one time it was thought that the injection led to obliteration of the sac of the tunica vaginalis, but this certainly does not occur; probably the injection diminishes the secreting power of the lining epithelium without impairing the absorptive power.

The radical cure of hydrocele consists in the removal of part of the whole of the parietal layer. When this method was first introduced, after the tunica had been incised and more or less of it removed, the wound was plugged and allowed to granulate up from the bottom; in fact, sometimes an incision was simply made without any removal of the parietal tunic; the method was effective, but very tedious. It is far preferable to excise the whole of the parietal layer and to close the wound; no drainage is required. The theory of the method is this: By removal of the parietal tunic we diminish the secreting area by at least half, and sometimes by much more in cases where the sac has been much dilated; moreover, what remains of the cavity is made to communicate with the extensive subcutaneous tissue of the scrotum, all the interspaces of which communicate freely with the lymphatic system, so that its absorptive power is almost unlimited. The method is very satisfactory, but the utmost care must be taken to secure asepsis, and it is recognised that it is exceptionally difficult to render the skin of the scrotum aseptic. The higher the incision is made, the smoother the skin, and the less the chance of sepsis, and by turning the tunica vaginalis inside out, it is possible to excise its parietal layer through an incision commencing immediately below the pubic crest.

The wound healed by first intention except for one stitch abscess. No recurrence took place.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, NOVEMBER 1ST, 1907.

The President, Sir **HENRY SWANZY**, in the Chair.

SOME UNUSUAL ABDOMINAL CASES.

Mr. **GRAVES STOKER** read a paper in which he gave the clinical history of a number of interesting abdominal cases. In one of these, a woman, who had suffered for a number of years from almost incessant vomiting and extreme emaciation, and who had been diagnosed by a late distinguished Dublin surgeon as having malignant disease of the stomach, obtained complete relief from her symptoms after an exploratory laparotomy in which the stomach was found to be quite normal. In another case, apparently of hydronephrosis, the patient, a woman, had the power of emptying the sac, whose capacity was several pints, more or less at will.

Dr. **WHEELER** said all the cases showed points of interest; and spoke with approval of the results obtained through the adoption of the method of continual saline injection as practised by Murphy, of Chicago. The theory advanced by Murphy to explain the great improvement in his results was that the lymphatic circulation in the abdomen was reversed, and the saline pouring in prevented the toxins of pus going the other way.

A CASE OF LIGATURE OF THE INNOMINATE ARTERY.

Sir **THOMAS MYLES** read his communication on this subject. In the course of his extremely interesting paper he described the symptoms and signs presented by a male patient, aged twenty-nine years, who suffered from a right sub-clavian aneurysm. He gave the reasons why he was led to reject treatment by Symes' method of opening the sac, followed by ligature of the artery on the proximal and distal sides, and also the treatment by distal ligature alone in favour of ligature of the innominate artery. The chief of these was that the most frequent cause of failure in previous attempts—namely, secondary hæmorrhage induced by sepsis—could now almost certainly be prevented. Most of these operations had been carried out in the pre-antiseptic era, while Mr. Coppinger's case, which was brilliantly successful, was performed with strict antiseptic precautions. He then discussed the methods of approach of the artery, finally selecting a median incision in the lower part of the neck, the ligature being accomplished without either division of the sterno-mastoid, resection of the inner end of the clavicle, or trephining the sternum. In addition to securing the innominate he placed a double ligature on the right common carotid dividing the artery between. He expressed the opinion that in carrying out this step he left too short a distance between the two ligatures, and that to this the failure of the operation was due. He then detailed the subsequent progress of the case, which was at first very favourable. The wound healed by the first intention, the pain caused by the aneurysm disappeared, and the patient felt very well. The pulsation in the aneurysm, however, persisted. About ten days after the operation a large subcutaneous hæmorrhage occurred, which was treated by reopening the wound and securing the bleeding vessel, which could not be identified. Subsequent hæmorrhages, however, took place necessitating further operations which for a time checked the bleeding. The wound now began to suppurate, the hæmorrhages continued to take place, and, finally, the patient died about a month after the first operation. The *post-mortem* examination showed that the source of hæmorrhage was the carotid artery from which one of the ligatures had slipped.

Mr. **WILLIAM TAYLOR** said there were, after all, only two reasons why success should not attend the effort to ligature the innominate artery—first, failure in the establishment of the anastomotic circulation of the brain; and, second, sepsis. One ought to be able to control the latter, and, therefore, should be able to control the secondary hæmorrhage. Yet they all knew how possible it was for some septic infection to creep in, and in Sir Thomas Myles' case it was just possible that there may have been some source of infection in the bottom of the wound in the deep structures. Barwell had drawn attention to the fact that death in such cases almost invariably arose from secondary hæmorrhage, and had stated that if ever he came to ligature the innominate artery he would ligature the vertebral artery as well as the innominate and carotid.

Sir **THOMAS MYLES**, in replying, stated his belief that the cause of failure was that the ligature on the common carotid had slipped.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM

MEETING HELD THURSDAY, NOVEMBER 14TH, 1907.

Mr. R. **MARCUS GUNN**, F.R.C.S., President, in the Chair.

Mr. J. **HERBERT FISHER** read a paper on some cases of

INTERSTITIAL KERATITIS FROM ACQUIRED SYPHILIS.

Before reading notes of four cases which he had personally observed, he expressed his surprise that so few instances of interstitial keratitis from acquired syphilis had been brought before the Society: this was the more regrettable seeing that Mr. Jonathan Hutchinson, when vacating the Presidential chair, had especially directed the attention of members to this subject as one upon which information might usefully be collected. The text-books dismissed the subject with very brief reference, and gave no authoritative statements as to frequency, date of onset, severity, and prognosis of the disease. After reading notes of his four cases, and alluding to one of corneal inflammation which rapidly followed the primary inoculation of syphilis on the lower eyelid, Mr. Fisher expressed his opinion that interstitial keratitis from acquired syphilis was generally a tertiary manifestation: that it appeared usually to attack only one eye, and that the infiltration frequently limited itself to a portion only of the cornea—that the keratitis, as far as it went, was identical in clinical appearances with that due to inherited disease, and that the statement which had been made by Nuel, that it was usually secondary to irido-choroiditis, was by no means universally accurate. Mr. Fisher further read notes of a case of interstitial keratitis in the child of a mother who had herself inherited syphilis, and who had in consequence suffered from kerato-iritis, with choroiditis and deafness. The question of the transmission of syphilis to the third generation was raised upon this case: assuming the husband of a woman, who had inherited syphilis, to have acquired syphilis, the point was raised whether she was more or less likely than a wife free from inherited taint to bear syphilitic children to him. Other practical points of discussion were raised, and members were invited to contribute their experiences, in hope that evidence might in time be obtained which would be of guidance both to ophthalmic and general surgeons, in answering the questions which might be addressed to them as to the advisability of marriage by patients who were the subjects either of inherited or of acquired syphilis.

Mr. **Thomson Henderson** (Nottingham) read a paper on the

ANATOMY OF THE SO-CALLED LIGAMENTUM PECTINATUM IRIDIS, AND ITS BEARING ON THE PHYSIOLOGY AND PATHOLOGY OF THE EYE,

a full abstract of which will be found under the heading of "Original Papers," page 543.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Clinical Evening.

Meeting held November 1st, 1907.

The President, Mr. **Richard Lake**, F.R.C.S., in the Chair.

The following patients were shown:—

Dr. **Arthur Saunders**.—A boy, æt. 6, with chronic disseminated myelitis. The patient was attacked with scarlet fever a year ago, this was followed a fortnight later by the onset of paraplegia with anæsthesia of the legs and lower part of the trunk. His condition has remained practically stationary since that time.

Dr. F. S. **Palmer**.—A boy, æt. 15. Primary progressive myopathy of the facio-scapulo-humeral type. No nervous disease in family. Five brothers and two sisters living and well. Patient was quite well until 18 months ago, when he first complained of fatigue and weakness in arms and shoulders, at the same time it was noticed that the facial muscles were weak. The wasting and weakness have been steadily progressive.

Dr. **Blair**.—(1) A youth with congenital absence of iris. In the right eye the iris is entirely absent, and the lens is deficient at its lower edge, and has a small anterior pyramidal cataract. The left eye has practically the same defects. His father and sister have somewhat similar congenital anomalies of the iris. (2) A case of misplaced pupils.

Dr. **Seymour Taylor**.—Man, æt. 34. Perforation of aortic valve. The patient had lead colic on two occasions, and has a typical blue line on the gums. While lifting a heavy weight experienced severe pain in upper zone of chest, choking sensation in throat, and faintness. There is a diastolic thrill all over the front of the chest, and a loud diastolic musical murmur is heard all over the chest, back, and front; also over the upper half of each humerus.

Mr. **McAdam Eccles**.—Man, æt. 45. Charcot's disease of left knee. Signs of locomotor ataxy for three years. The pupil reaction is only present on the left side. The joint became largely distended with fluid in three days and without pain. Fifteen ounces of fluid were aspirated from the joint, and a plaster case applied. While this was on no re-collection of fluid took place, but on its removal the joint became distended in the same time as before.

Mr. **Aslett Baldwin**.—(1) Female, æt. 29. A case of excision of the rectum for carcinoma by an abdomino-anal method. Admitted with complete intestinal obstruction of 10 days' duration. Colotomy was performed. Later the abdomen was reopened and the attachments of the rectum divided as high as the sigmoid flexure. The anus dilated, and the bowel and growth forced out through the anus, forming an intussusception. This was cut off externally, and the bowel united by circular suture and returned. The sigmoid is attached a short distance above the anus. The patient has perfect control and normal action of bowels. (2) Man. Lengthening of left leg and extensive nævus of left half of body. A venous nævus occupies the left side of the trunk and most of the left thigh, leg and foot. The left leg is 2½ inches longer than the right, and the left foot is ½ inch longer, but the left calf measures 11½ inches in circumference, whereas the right measures 13 inches. Varicose veins are also present in the left leg. (3) Man, æt. 30. Carcinoma of right breast. Noticed lump about 10 months, which has been ulcerated about a month. Two secondary growths in skin near the primary one, numerous hard, enlarged glands in axilla. A microscopical section of one of the secondary growths showed typical scirrhus carcinoma. (4) Girl, æt. 4. Tumour of scapula, etc. The enlargement of the right scapula was noticed two months ago. The lower end of the right fibula is markedly thickened, and nodules can be felt on the metacarpal bones and phalanges of the right hand. There appears to be no pain or tenderness.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held November 7th, 1907.

Mr. T. H. **Bickerton**, Vice-President, in the Chair.

AN UNUSUAL CASE OF ATAXIA.

Dr. F. J. S. **Heaney** described and showed a case of ataxia presenting an unusual combination of symptoms and some difficulty in diagnosis. The patient, a painter, æt. 52, developed a spinal curvature in the dorso-lumbar region when two years old, presumably as the result of caries. The curvature had caused no symptoms, and the patient had never had syphilis. Ataxia, Rombergism, absence of knee-jerks, numbness of the feet, and diminution of pressure sense over the lower extremities appeared six months ago. There were no Argyll-Robertson pupil phenomena, no lighting pains, and no interference with the fields of vision or with cutaneous sensation. Muscle power and sphincters were normal. Cutaneous reflexes were normal, the plantar being flexor in type. The only alterations in his condition in the last six months were a transient left ankle clonus and a recent slight return of right knee-jerk. The differential diagnosis between tabes, combined system degeneration, and recurrence of spinal caries with focal myelitis and posterior column degeneration was discussed, Dr. Heaney deciding in favour of the last diagnosis.

Dr. T. R. **Bradshaw** said that the unusual feature in the case was the temporary restoration of the knee-jerk. The present condition, apart from the history, would justify a diagnosis of tabes, and often in cases which were obviously specific, no history of infection could be obtained. The Argyll-Robertson pupil was only observed in about 80 per cent. of cases of tabes. If the knee-jerks returned again, he would suggest that the ataxia was due to a neuritis possibly caused by lead (there was a history of lead colic), producing a condition analogous to alcoholic pseudo-tabes.

Mr. R. J. **Hamilton** gave a short description of Kroenlein's operation, and showed a successful case in which this operation had been done for a tumour surrounding the optic nerve and causing considerable proptosis. The tumour was a spindle-celled sarcoma, and measured 1⅓ by 1⅛ inches. The results were—an eye with good vision, perfectly free movements, and very little scarring in the temporal region, the seat of the incision.

Dr. K. **Grossmann** remembered being consulted by the same patient, who had been told at an eye hospital that the proptosis was due to one-sided exophthalmos, and recommending an operation. At that time a hard tumour could be felt between the lower outer orbital margin and the eyeball, and it was an open question whether it could not have been removed by a simple incision along the lower margin of the orbit. He considered that Kroenlein's operation was suitable for cases of retro-ocular tumour which could not be removed from the front without severe damage to the eyeball. Dr. Grossmann described some of the modifications of the operation.

Dr. **Stoopes** and Mr. E. M. **Stockdale** also spoke.

Mr. C. **Thurstan Holland** showed, and explained the working of, the Levy-Dorn Orthodiagraph, which had been in use at the Royal Infirmary since last June. This pattern allowed of the patient being examined either lying down, standing, or sitting. It was pointed out that the lying down position was undoubtedly the best, and for this Mr. Holland had found the instrument devised by Professor Moritz the more reliable and the easier to work. Tracings of hearts at different ages were passed round. Mr. David Morgan gave his experience of this and other methods.

Mr. Douglas-Crawford read a note upon two cases associated with elongated meso-cæcum: (1) Volvulus of the cæcum in a woman, æt. 39, the torsioned mass lying above the umbilicus on the left side. Early operation resulted in a successful untwisting of the mass, and the patient made a good recovery. (2) Malignant cæcum in a man of 35. The "lump" lay in the right lumbar region, moved freely with respiration passing up behind the liver, and down as far as the iliac crest, but not reaching the iliac fossa. The mass was excised, and later the fæcal fistula closed, but only after a lateral anastomosis had been effected between the ileum and the transverse colon. The patient was perfectly well one year after the excision of the growth.

Dr. F. M. Gardner-Medwin gave a demonstration of the ROTH-DRAGER OXYGEN-CHLOROFORM APPARATUS, with a short note and report on 25 cases. The advantages of the apparatus were—regular doses of known quantity and the easy control of the concentration of atmosphere. It was compared with other mechanical apparatus, and stated to be of great value in serious cases when ether narcosis was contra-indicated. The cases reported were all serious ones and mostly of long duration. They all showed complete absence of cyanosis, and in cases where ether had caused profuse salivation and venous engorgement the apparatus was particularly useful. One case of empyema, although the patient was unable to lie down and coughed up pus continually, after a few breaths of free oxygen easily bore the gradual exhibition of chloroform, and was able to lie down and take the anæsthetic quite easily.

Dr. Fingland said that the method of administering oxygen with chloroform was suggested by Mr. T. G. H. Nicholson, of Liverpool, some years ago, and that his apparatus was figured in the *British Medical Journal* in 1896. Mr. Nicholson's theory was that the lessened blood pressure produced by chloroform, and the corresponding slowing of respiration and circulation, interfered with the elimination of carbonic acid and caused its accumulation as an active toxine, which condition would be prevented by the administration of oxygen with the chloroform vapour. But Dr. Fingland was of opinion that the effect of the admixture of oxygen with the chloroform would be to inhibit to some extent the combination of chloroform with the red corpuscles of the blood, and by this means remove the real danger of chloroform narcosis. After referring in detail to several points of the Roth-Drager apparatus, he suggested the more extensive use of ether by the Rochester method of administration as possessing the advantages of a safe and natural anæsthesia.

Dr. F. W. Bailey thought that the length of time required for induction, and the difficulty which would be probably met with in the case of full-blooded, strong workmen, and the complications of the apparatus, would prevent it coming into general use in hospital practice, while its cumbersomeness and want of portability would make it difficult to use in private practice, and furthermore, he saw difficulties in the way of using it for mouth operations. The administration of anæsthetics could not be reduced to "rule of thumb."

Mr. G. P. Newbolt said Dr. Medwin had used the apparatus many times in major operations on patients under his care. He was convinced that it was a most efficient way of administering chloroform. Patients appeared to suffer less from shock, and their condition was better than when chloroform was given by one of the usual methods. He was not certain whether the oxygen caused some slight bronchial irritation, and suggested that it should be warmed before being inhaled.

The Public Health Committee of Leith Town Council, at a meeting on November 12th, agreed to recommend the Council at their January meeting to adopt the new Notification of Births Act. They also resolved to ask a remit from the Town Council to introduce a system of supplying Buddeised milk.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Nov. 17th, 1907.

BRONCHO-PNEUMONIA IN YOUNG CHILDREN.

Broncho-pneumonia affects particularly scrofulous children or those with some hereditary taint, but also children recovering from some secondary affections as grippe, measles, diphtheria, whooping cough, and is particularly prevalent in the winter season. Overcrowding in schools exercises a real epidemic influence where the dust carries, not a specific microbe as has been proved, but variable micro-organisms distinct from the agent of the initial cause. All kinds of germs are found, pneumococci, streptococci, baccilli of Friedlander, to which are added the septic flora of the buccal cavity and of the air inspired. Hence the necessity of careful antisepsy of the nasal fossæ and of the mouth, and the periodic ventilation of the school rooms.

The bases of the lungs are first affected; dry crepitating râles constitute the first signs, followed soon afterwards by murmur, at first soft, then loud and frequently surrounded with sibilant râles.

The dyspnœa is intense, the cough short and painful. Very young children do not expectorate, but those of two or three years expectorate mucus at the period of coction.

Antisepsy of the nasal fossæ and the mouth is always necessary. For the former, the following ointment should be introduced:—

Salophen, ½ dr.
Boric acid, ½ dr.
Menthol, 11 gr.
Vaseline, 1 oz.

While the mouth and throat should be sprayed with:—

Phensalyl, 10 gr.
Chloride of sodium, ½ dr.
Boiled water, 1 pint.

The patient should be isolated from other children, when possible, and kept in a warm room, and the air charged with the vapour of eucalyptus and thymol:—

Eucalyptus oil, 15 gr.
Menthol, 15 gr.
Thymol, 15 gr.
Ess. of lavender, 1 dr.
Tincture of tolu, 2 dr.
Proof spirit, 4 oz.

A teaspoonful in a saucepan of boiling water and covered with a funnel. Where this method cannot be employed, essence of turpentine poured on a plate placed near the bed of the child and renewed from time to time is good practice, as turpentine sends off ozone vapors.

Revulsives, such as cupping, blisters (carefully dressed with iodoform ointment), warm poultices powdered with mustard, are always indicated, but in very young children rubefacient friction with the following liniment should be preferred:—

Ess. of turpentine, 1 oz.
Liq. ammonia, ½ dr.
Lini sinapis co, 1 dr.
Lavender spirit, 2 oz.

Under five years of age, the lower extremities of the children should be enveloped in absorbent cotton, covered with impermeable tissue in order to provoke sudation of the limbs with consequent vaso-dilatation of the vessels.

Calomel, quinine, aspirin are indicated during the first few days, and the heart should be sustained with digitalis, rum, punch, etc. When expectoration appears it should be encouraged by

Antimonial wine, 20 drops.
Syrup of poppies, 1 dr.
Gum water, 4 oz.

A teaspoonful every two hours.

ARTIFICIAL ABSCESS.

Artificial pyogenesis, says Prof. Thiroloix, should always be regarded as an exceptional method reserved for the gravest cases, those that might be called "desperate." It should never be currently employed, as in the first place it provokes great pain, and, secondly, it requires during its development careful aseptic treatment.

When, in presence of acute or sub-acute septicæmia (without localised visceral suppuration), due to streptococcus, staphylococcus, or pneumococcus, and resulting from an attack of grippe, pneumonia, broncho-pneumonia, from scarlatina, typhoid fever, or puerperal injection, the first treatment should consist in injections of antistreptococcal serum or preparations of yeast. If this agent has no effect, intravenous injections of collargol should be tried:—

Collargol, 15 gr.
Sterilised water, 4 oz.

One drachm injected into the cephalic vein or one of the large superficial veins of the leg.

Subcutaneous injections of nucleinate of soda (1 gr. every six hours) have also a salutary effect.

If all this treatment seems of little avail, a last chance should be given to the patient by the creation of an artificial abscess. For this purpose the region selected for the abscess (flank, deltoid region, middle and external third of the thigh) should be disinfected by soap and water, followed by proof spirit and ether. With a sterilised hypodermic syringe, 20 drops of essence of turpentine are injected into the cellular tissue and the parts immediately covered with antiseptic gauze.

A few hours after the injection the patient complains of smart burning pain, and soon patches of inflammation appear, and the region becomes œdematous. This diffuse inflammation lasts one or two days, when the tumefaction becomes circumscribed, the pain disappears, and the abscess begins formation. The reaction can be either nil, moderate, or acute. Where it is nil, the prognosis is very grave, as it indicates that the infection is going to terminate fatally. The organism is not able to react to the solicitation of the chemical agent. Where the reaction is moderate, the abscess continues to slowly develop. In such cases it should not be opened too soon, and, above all, not until all unfavourable symptoms have disappeared. Perhaps the creation of another abscess may be necessary. In any case, subcutaneous injections of nucleinate of soda should be given as a general stimulant to the organism.

Acute reaction of artificial abscess is a very good sign, and renders the prognosis very favourable.

GERMANY.

Berlin, Nov. 17th, 1907.

The *Archiv. f. Klin. Chirurgie*, 83, I., contains a paper by Dr. Berger on

Injuries to the Abdomen by Blunt Force,

in which four cases of operation of special interest are related.

The first was a case of rupture of the spleen. A soldier, 19 years of age, fell out of bed, striking the left side of his body on the corner of a footstool. The general symptoms (great pallor, an anxious expression of face, difficult breathing, small frequent pulse) pointed to hæmorrhage into the abdominal cavity; the local symptoms (increased dulness in the splenic region that did not change on change of position, and abrasion of the skin over the ninth rib) pointed to the spleen as the source of it. The anæmia, which was rapidly increasing, demanded immediate operation. This, performed 24 hours after receipt of the injury, showed a rent in the spleen 8 cm. in length, reaching to the hilus, with blood still flowing from it. Plain signs of internal hæmorrhage had not shown themselves until within 12 hours of the injury. As the quickest and safest mode of treatment, ligature and extirpation of the injured organ were performed. In the after-treatment saline infusions were many times demanded and made use of. Eight weeks after the operation the patient was quite well, with the exception of some paleness, which the writer attributed to slowness in blood regeneration. No swelling of the lymph glands or of the thyroid was observed. The literature of cases hitherto published (241 cases) gave the mortality as 39 per cent (2) Traumatic cholecystitis. There were two cases of this. In the first case a man was thrown from a horse, dragged 50 yards, and received several kicks on the right side, after which a chronic cholecystitis developed. At first there was great pain without any objective symptom; later on the pain diminished, and at times ceased altogether. At last attacks came on with great pain in the region of the liver, vomiting, slight jaundice, and some fever. An operation, performed three months after the injury, showed cord-like adhesions between the omentum and the anterior abdominal wall, firm adhesions between the lower margin of the liver and the same wall, and the gall-bladder, which was free of stones, and was long, flaccid, and half-filled, was adherent to the colon. Cystotomy was performed after separation of the adhesions. Permanent closure of the fistula took place four months later.

In the second case a woman fell with her right side on to the edge of a water pail. The day after she felt a longish movable tumour in her right side, but felt well. On the second, symptoms of peritonitis appeared which indicated a serious condition. An operation showed the presence of gall-stones (17 in number), which, as they were formed into a firm conglomerate, had not up to then set up any irritation of the mucous membrane. It was only the injury caused by the fall in which the mucous membrane was bruised between the sharp edge of the pail and the gall-stones that permitted the invasion of bacteria to set up any injury. Here again cystotomy only was called for, and healing was complete 39 days after the operation.

The next was a tumour of the mesentery after an injury. This case proved fatal, but the surprising condition met with at the autopsy made it very interesting. A soldier, æt. 24, who had previously always been healthy, felt a violent stabbing pain in his right side as he sprang over a ditch, but did not make any complaint until four days afterwards. At first some tenderness on the right side of the abdomen, with slight resistance, gave rise to a suspicion of typhlitis. In the evening, after energetic bodily movement, there was considerable increase of pain, along with vomiting, and the following morning a tumour the size of a child's head was felt to the left of the umbilicus. Vomiting was present with meteorism, no flatus or stool passed, and the pain was extremely violent. On an operation being performed, a tumour of the mesentery was found that had been latent up to then, but which had got considerably larger through hæmorrhage into it. The tumour was a sarcoma. Drawn out over the tumour, flattened like a cord, and rather sharply kinked, ran the ureter, too much compressed to allow the urine to flow freely, so that the kidney was in a state of acute hydronephrosis. The tumour could not be completely removed, as it passed too deeply down. The next morning collapse took place, with loss of consciousness, rigidity of pupils, convulsions both of the trunk and extremities, and later on Cheyne-Stokes' respiration. As uremia was suspected, the right, kinked, ureter was drained. The breathing became quieter and the convulsions ceased. The following morning, however, the patient died, in spite of saline infusions and excitants. The autopsy quite cleared up whatever was doubtful. There was a tumour (sarcoma) the size of a hen's egg of the posterior lobe of the brain, numerous metastases the size of walnuts in both lungs, a metastatic tumour of the glands extensively adherent to the vena cava, and to some extent penetrating it.

It was remarkable that all these growths had so little affected the vital organs that the soldier was on duty up to a few days before his death. All that had been observed was that for a few weeks he had been morose and negligent, there had been twitching of the left eye, and he had once complained of weakness of sight. The cause of death was the cerebral hæmorrhage, of which the first symptom was the vomiting that took place the day after the operation.

AUSTRIA.

Vienna, Nov. 10th, 1907.

Radiation and Necrosis.

At the Gesellschaft, Churmont exhibited a case on which he had repeatedly operated for empyema in the frontal bone from excessive use of the Röntgen rays. By separating a portion of bone and periosteum from the margin of the wound, he succeeded in closing the wound completely.

Schopf recorded a similar case of an osseous defect in the left frontal bone involving the orbital margin and ethmoid bones. He used Fraenkel's celluloid heteroplastic appliance, and obtained an excellent result, both cosmetically and functionally.

Hypertrichosis.

Halban showed a gravid guinea-pig with an enormous profusion of hair on the body which always occurred in pregnancy. He has devoted two years to this subject in the lying-in hospital, and finds this is the case in the skin of females of the human sex also.

Detachment of the Retina.

Sachs described what he termed a new method of treating detached retinas, and exhibited a woman, æt. 49, on whom he had performed the operation for blindness of the right eye owing to the retina being completely separated from the sclerotic base. Later the left eye commenced in the upper quadrant, which he treated by puncture, injections of a salt solution, and a bandage.

His new operation for the right eye was described as first anæsthetising by means of cocain, separating the superior rectus muscle, then with a curved knife cutting the ball equatorially parallel to the ora serrata, and liberating the serous fluid from below the retina. The result was a replacement of the retina, and a rapid healing of the linear incision, as the precaution of cutting the rectus muscle hastens the repair. In this case a small amount of fluid collected afterwards behind the retina between the cicatrix of the incision and the ora serrata, but this did not interfere with the field of vision. He thought this opening produced a mole or dam to the extension backwards of the fluid. He had operated on several cases with perfect success, and thought he saw in this operation as great a future as that of aspirating the thorax for pleuritic effusion.

Müller thought that great caution was necessary where ablatio retinæ existed, as other operators in different countries had not obtained such favourable results—indeed, they condemn the operation as absolutely injurious. Every form of puncture was deleterious and damaging to the eye, more particularly in those advancing in life.

Secondary Vaccination.

Mautner showed a child from Prof. Monti's Klinik, æt. 5, with secondary vaccination on the right side of the tongue. The child was vaccinated on the right arm previously, which took very well, but after the vesicles of the arm broke it became very itchy, which caused the child to rub them with its fingers, which it subsequently put in its mouth, with the result that a large vesicle formed on the right side of the tongue. The child appears to have had a carious tooth that cut the tongue in the first place, admitting the virus to the system, and producing the usual primary vesicle. Now arises the question—would the child have taken small-pox as easily as if it had never been done in the first instance? It seems all the susceptible matter was not used up, or the second vaccination should not have been successful. This subject is still far from satisfactory.

Necrosis of Bone.

Eiselsberg showed a patient on whom he had operated for necrosis in the upper arm. The entire humerus was removed, but the periosteum preserved, from which restitution was expected. The function of the arm was now good, while the muscles were strong, and the grip of the hand as firm as ever. The Röntgen rays revealed a small lamella of bone at the distal end of the humerus, and a small spicula about the middle of the upper arm. The upper arm can be twisted round 360 degrees, entirely checking the pulse at the radial artery.

A Giant Growth.

Kienböck, amid some amusement, brought in an Anak, æt. 27, in excellent health. He was 202 centimetres, = 6 ft. 8 in. in height, and weighed 90 kilos., or 15½ st. The hands and feet were proportionately long, 24 and 32 centimetres respectively. The cranium was not increased in proportion to the body, being 56.5 centimetres in circumference; forehead low and face long; heart orthoscopic on the Röntgen shadow, and measuring 13 centimetres horizontally.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Clinical Teaching in Glasgow.—A discussion on this subject has been going on in the columns of the daily Press for some weeks, the question at issue being whether the Western Infirmary is able to give adequate instruction, or whether the other Glasgow hospitals should take part in clinical teaching. Though there is no compulsion on the students to attend the Western Infirmary, its proximity to the University and the fact that the Clinical Professors, who are the examiners, teach there, offer a strong inducement to the students, with the result that some of the clinics are overcrowded. It is suggested by way of remedy that all the Glasgow clinical teachers should be made examiners, whether they are attached to the Western Infirmary or not, and that cars should be run at special hours, so as to get over the difficulties of distance. The supporters of the *status quo* urge that what is required is a more uniform distribution of the students among the clinics of the Western Infirmary. On the medical side of the hospital the students are fairly well divided among the examining and the non-examining physicians, but on the surgical side two-thirds of the students crowd to one teacher of clinical surgery, while the remaining five teachers, though one is an examiner, have only one-third of the students. Evidently, therefore, it is very desirable that some means of dividing the students among the six surgeons should be devised; were this done, it would be easy to limit the clinics to about 25 men, and to arrange that each student should attend the wards of several teachers in succession.

Edinburgh University: Lord Rector's Assessor.—The Rt. Hon. R. B. Haldane has appointed Mr. James Walker, C.A., his assessor on the University Court in succession to Lord Dundas. No better representative of the interests of the students could have been selected than Mr. Walker, who for years as treasurer of the union has laboured indefatigably on their behalf. His appointment will be deservedly popular.

Glasgow Graduation Ceremonial.—The disorderly scenes which were witnessed at the recent graduation ceremonial were discussed at a mass meeting of the students held on the 11th inst. A resolution was passed expressing regret at the disorder, particularly as it had been construed as showing a lack of sympathy with the Principal, and apologising for the same. Mr. Watson, President of the S.R.C., said he confessed they had unwittingly insulted the Principal—at least he regarded their conduct in that light. In view of this, the only manly course was to offer an apology to Principal MacAlister. The apology was to the Principal personally, not to the Senatus. Two students were appointed to wait on the Principal, and convey the apology to him in person. The cause of the disturbance is alleged to be the insufficient accommodation provided in the Bute Hall. It had been desired to secure the St. Andrew's Hall for the graduation, but the proposal was overruled by the Senatus—hence the rowdyism.

BELFAST.

The Irish University Question.—The questions connected with Irish University education, and specially the question of the desirability or otherwise of having a Northern University in Belfast, are a good deal before the public now, partly on account of Mr. Birrell's recent speech, and partly on account of the plain words of Lord Kelvin in his address read at the opening of the new laboratories at Queen's College a few weeks ago. During the past week there have been two public references to the question in Belfast. On Monday night Professor Moore, of Liverpool, gave an address to the Medical Students' Association at Queen's College, in which he dealt with University education generally, and referred specially to local conditions in Ulster. He expressed in the strongest possible terms his belief in the desirability of an Ulster University and his confidence in its success. On Friday, at the distribution of prizes by Lord Shaftesbury, the Lord Mayor, to the boys of the Royal Belfast Academical Institution, one of the speakers, Mr. R. T. Martin, a solicitor closely connected with College affairs, spoke in much the same sense. There can be no doubt that the public generally is being educated up to the idea of a local University, and a project which a few years ago was openly derided and scoffed at by most University men, and all non-University men, is now seriously discussed on all sides, and received with a large amount of favour.

The Milk Supply.—Mr. Nathan Strauss, of Heidelberg, has offered to the Belfast Corporation a complete outfit for the Pasteurisation of milk, but the offer had to be refused, as the necessary expenditure for the working of the scheme would not be legal, and would certainly be surcharged by the Local Government Board auditors. Mr. Alec Wilson, whose model dairy at Belvoir Park was inspected by Lord and Lady Aberdeen during their recent visit to Belfast, has written an interesting letter to the local Press on the question of tuberculosis and milk. He says that experience shows clearly that a slight increase in price will pay the dairyman well for his trouble in cleaning up and supplying milk for which he can produce medical and veterinary certificates; but to sell milk warranted free from tubercle is a much more serious affair. If one is content with a certificate that there are no clinical signs of tubercle, and that the udders of the cows are free from disease, the milk may be sold at fourpence a quart from the dairy worked on modern hygienic lines. But to warrant the milk free from tubercle means the systematic testing of the cows with tuberculin, and the slaughter of some 30 per cent. of those tested, as well as many precautions to avoid infection by other tuberculous animals, such as pigs. This in practice will add about 25 per cent. to the price of the milk, and it remains to be seen whether there is a demand for such milk. If there is, it will soon be supplied.

LETTERS TO THE EDITOR.

DISEASES OF TWINS.

To the Editor of The Medical Press and Circular.

Sir,—Will you kindly permit me to make use of the columns of your medical journal under the following circumstances?

On re-reading Francis Galton's "History of Twins," published in his work, "Inquiries into Human Faculty," it occurred to me that, as he has proved the greater strength of Nature over Nurture in this investigation, the same material slightly modified would be able to conclusively establish the relative importance of the factors of individual constitution and specific invading organisms in the production of disease.

Accordingly, I had, as a beginning, 200 circulars and addressed return envelopes printed, and subsequently dispatched a little over 50 of them to test the kind of response I was likely to meet with. I had replies from over 40 per cent., and although I took the precaution of sending only to general practitioners of more than ten years' standing, the evidence obtained was decidedly disappointing. I had imagined, as twin births are said to occur once in about every 90 maternity cases, that most practitioners who had been in practice for a few years would have had some experience on this subject, even allowing for the fact that twin children frequently die.

To my surprise, no less than 45 per cent. of my replies stated that no experience had so far been obtained; 8 to 10 per cent. apparently do not practice midwifery, or discourage it, and have not attended twins at any later age period; and only 45 per cent. have had any experience, however meagre. Of these, most appear to have had a few maternity cases, though the answers were not always clear on this point: in addition, 25 per cent. have once attended twin children and 30 per cent. once adults. I am not quite certain whether one of these latter did not attend adult twins twice.

The number of replies is, of course, far too small to make any generalisation upon the matter. A practitioner may possibly be unaware that he is treating a twin when the pair are separated. Still, allowing for this, the scarcity of material is remarkable. The explanation may be possibly due to an error in assuming that hospital statistics, drawn from the poorest citizens, apply equally to all classes. In any case, it is evident that I must appeal to a much larger circle of medical men than can be done by any method of private correspondence, in order to obtain the necessary information.

Would any of your readers, therefore, who have in their possession evidence on the points mentioned below, kindly communicate with the writer whose address is appended?

Twins, if they are true twins, are usually of the same sex, and are most frequently either much alike or much unlike.

(1) Of like twins of the same sex at any age period, have you any medical experience of their suffering simultaneously or independently from like or unlike diseases in like or unlike (separate) surroundings?

(2) Of unlike twins of the same sex at any age period, have you any medical experience of their suffering simultaneously or independently from like or unlike diseases in like or unlike (separate) surroundings?

Please name specifically all diseases referred to, as this point is very important.

Any additional information on the subject would be welcomed, and all remarks will, of course, be treated confidentially.

I would be greatly obliged if Continental journals would insert this letter in their issues.

Thanking you and your readers in anticipation for your kindness in considering my letter,

I am, Sir, yours faithfully,
J. Lionel Tayler, L.R.C.P., M.R.C.S.
8, Adys Lawn, Willesden Green, London, N.W.

ANTI-TUBERCULOSIS DISPENSARIES.

To the Editor of The Medical Press and Circular.

Sir,—In your leading article of yesterday on the Medical Officer's report to the Local Government Board, you lay due emphasis on the significance of anti-tuberculosis dispensaries. The article suggests, however, that these are extra-British in conception and development. You suggest that they constitute a French experiment, worthy to be carefully watched with a view to possible imitation. I would remind you, however, that both the conception and evolution of the anti-tuberculosis dispensary are essentially British.

In the campaign against tuberculosis, which was initiated in Edinburgh in 1887, "the first step" (I am quoting from the official report) "was the establishment of the consumption dispensary. The purpose of the dispensary was the formation of a central institution, to which persons of the poorer classes, affected by tuberculosis, might be invited and directed. The idea was a novel one twenty years ago. For more than a decade the Victoria Dispensary for consumption was alone of its kind. Familiarity with its object has led more recently to widespread recognition of the significance of the Dispensary. During the past half-dozen years, consumption dispensaries have been created in Belgium, France, and Germany, and in the last year or two similar dispensaries have been founded in America, the United Kingdom, and the Colonies. It is matter for congratulation that the conception has proved to be of such universal application and value."

In the important Memorandum on the Administrative Control of Pulmonary Phthisis, issued by the Local Government Board for Scotland on March 10th, 1906, the significance of dispensaries for pulmonary phthisis is thoroughly recognised. "In towns and other thickly populated localities, where the number of phthisical patients is large, the local authorities will find it advisable to institute a dispensary or dispensaries. In Edinburgh, the Royal Victoria Dispensary for Tuberculosis, organised by Dr. R. W. Philip, has worked successfully for 18 years, and the suggestions here made are largely based on the experience of that Dispensary."

At the inauguration of the new buildings in connection with the Royal Victoria Hospital for Consumption on October 25th last, Dr. Leslie Mackenzie, speaking on behalf of the Local Government Board for Scotland, said:—"We adopted his scheme as a national system for the administration of the campaign against tuberculosis in Scotland. The Dispensary in Dr. Philip's scheme is the centre, the exchange, the information bureau, the nucleus of the whole system. In the Victoria Dispensary we have a type of what we hope to see realised in the district of every local authority in Scotland. The function of a Dispensary is to act as an information bureau, a supervision bureau, a centre of treatment for such patients as do not need hospital treatment, but who can benefit by supervision at their own homes."

These quotations will, I think, suffice to show that the Consumption Dispensary is no longer at the experimental stage, nor does it seem necessary for us to go outside our own country for a working model.

I am, Sir, yours truly,
Alexander Christison, Bart., M.D.

Edinburgh, November 15th, 1907.

HOT-WATER OPERATING TABLES.

To the Editor of The Medical Press and Circular.

Sir,—As I can claim priority for suggestion of hot-water operating tables as a preventive of shock during, or subsequent to, sustained operations (abdominal or otherwise), I should feel much obliged if any members of the surgical staff of hospitals would kindly state their opinion of such a form of table. My suggestion (which was adopted by most surgical instrument-makers, and who still stock the said table) appeared so long ago as 1889 in The Medical Press and Circular and the other medical papers, so there has been ample time to judge of the practical value of my suggestion, and I should much value the opinion of those who have found it has contributed to the prevention of shock and the assistance to recovery after operation.

Yours very truly,
Alexander Duke, M.D.

London, W.

A ROYAL COMMISSION ON QUACKERY.

To the Editor of The Medical Press and Circular.

Sir,—One of your medical contemporaries has sought to throw some cold water on the project of a Royal Commission on illicit practice, by the statement that medicine is not an exact science, and that quacks would produce patients who had been cured under their treatment, and thus would scatter dust in the eyes of the Commissioners. Does the State ask whether political economy and the operations of the money market are exact sciences before devising laws to protect the people against common swindlers, burglars, and pick-pockets? The State acknowledges that its duty is to protect the people, and especially the weak and simple, against the wiles or the violence of the predatory classes. If the arts of medicine and surgery together could not claim a single scientific fact upon which to base themselves, it would be still easy to demonstrate to all sensible men the fact that fraudulent quackery is founded solely upon falsehood—a mass of lies gross as a mountain, open, palpable. Many cases within late years in the civil and criminal courts have shown that the production of many patients "cured" by quackery is not enough to prevent the ruin of a quack even when defended by leading counsel. The average juryman is quite able to recognise that the quack's claim as a healer really amounts to a claim to be a miracle worker; and the juryman can see that miracles cannot be wrought in the removal of organic disease by the inert messes in way of drugs, or the bogus apparatus, which form the stock-in-trade of the quack. In civil cases where the exposer of quackery is on his defence—and even the difficulties which civil procedure gives rise to are great—the quack always comes out a sorry figure; how much more certainly would he fare badly before a tribunal like a Commission, which, although it might include some weak or prejudiced members, would be composed in the main of sober-headed men of judgment. The result of the Australian one-man Commission, has, it seems to me, demonstrated the practicability and the hopefulness of a Commission (which would be armed with much wider powers at home); and I sincerely trust that you will continue to exert your influence in support of the movement first suggested in your paper.

Yours, etc.,
Reformer.

November 15th, 1907.

[We should welcome the outspoken views of readers on this most important and practical of professional topics.—Ed., M. P. & C.]

OBITUARY.

SIR CHARLES F. HUTCHINSON, J.P., M.D.Ed., M.R.C.S.

It is with great regret that we record the death of Sir Charles Hutchinson, which took place last week. It was known that Sir Charles had been desperately ill for some time, but the accounts had been more satisfactory of late, and his friends hoped he had weathered the storm. Sir Charles Hutchinson was educated at Edinburgh University, where he graduated M.B. and C.M. in 1872, and M.D. in 1874. After some preliminary steps, he settled down in practice in the Riviera, where he attained great popularity, and had a large clientèle for many years. He gave up practice to stand for Parliament, and he will always be remembered in political circles as the "Victor of Rye." His sensational victory in that constituency was the harbinger of the many late Liberal victories at the polls. Unfortunately he lost his seat at the General Election, though he was wont to say he helped sixty other candidates to win theirs. All who knew Sir Charles Hutchinson, whether they were on his side of politics or not, were his admirers. His genial presence, his warm heart, his witty speeches, and his racy manner won all hearts. His defeat at the General Election pained him greatly, as in Parliament he was in an atmosphere that just suited him. The Government, by way of consolation, gave him a knighthood, and we are sure it was as popular an honour as any in the list.

FLEET-SURGEON FREDERICK HARVEY, M.R.C.S.

We regret to record the loss of Fleet-Surgeon Frederick Harvey, whose death took place on November 12th, in his 89th year. He entered the Navy as an assistant surgeon two years after Queen Victoria ascended the Throne. The first vessel to which he was appointed was the "Beacon," employed on surveying duty in the Mediterranean. He was employed on similar duty in the following year, and during the winter of 1842-43 was in medical charge of the officers and men appointed to search for sculptured tombs and marble antiquities in Xanthus. In 1849 he was promoted to the rank of surgeon, and joined the "Sphinx," Captain C. F. A. Shadwell, in the East Indies. When trouble arose with Burmah in 1852, in this vessel he took part in the various operations, and received the medal and clasp. He was promoted to Fleet-Surgeon in 1861, and retired from the active list in 1874. He was awarded a Greenwich Hospital pension in 1894.

A. MacTIER PIRRIE.

We regret to announce the death, at the early age of twenty-eight, of Dr. A. MacTier Pirrie, who, after gaining high honours, including the Carnegie Research Fellowship, in anthropology, was appointed anthropologist to the Wellcome Research Laboratories at the Gordon Memorial College, Khartoum, and went out to the Soudan in the autumn of 1906. Under the direction of Dr. Andrew Balfour, the director of the laboratories, Dr. Pirrie made his first expedition up the Nile to the southern limits of the Soudan, and penetrated to remote parts of the Bahr-el-Ghazal. A second expedition took him to the borders of Abyssinia.

On the latter occasion he contracted fever, and was compelled to return to England. He presented a paper on his expeditions at the last meeting of the British Association, but was prevented from being present on account of his illness. Dr. Pirrie brought back a valuable collection of objects of anthropological and other scientific interest, and at intervals during his illness he was engaged on his report to the Carnegie Institute and the Wellcome Research Laboratories, Khartoum, for which institutions he acted jointly in the work he carried out in the Soudan.

JOHN GARNER, M.A., DUB., L.R.C.S. AND P., ED.

Dr. John Garner, Inspector-in-Chief of the Egyptian Public Health Department, died at Cairo on October 26th after a short illness. He was third son of Dr. W. Hastings Garner, for over 30 years Resident Medical Superintendent of Clonmel Asylum. He was a graduate in arts of Trinity College, Dublin, and L.R.C.P.S., Edinburgh. He began his professional career as assistant surgeon of the Co. Down Infirmary, and, after some subsequent service, went out with the Austin expedition for the delimitation of the Abyssinian frontier in the capacity of surgeon in charge. On his return from this expedition he obtained a post in the Egyptian service, in which he worked until his death. In 1905 he married Miss Hastings, of Downpatrick, and so leaves a young widow to mourn his early death.

ROBERT FITZROY BENHAM, M.R.C.S.

We regret to announce the death of Mr. Robert Fitzroy Benham, of Earl's Court Square, a well-known surgeon, who founded the Queen's Jubilee Hospital, Richmond Road, Earl's Court, which has since been re-named the Kensington General Hospital. Mr. Benham, who was fifty-four years of age, was the inventor of numerous surgical and other appliances. He was educated medically at St. George's College, and took the diploma of M.R.C.S.England.

LITERARY NOTES.

We are at a loss to conceive what motive could have prompted Dr. Herbert Hart to publish "Some Successful Prescriptions," written, we are informed, "on Monday, August 12th, 1907, after the evening surgery." Under the head of "Skin Diseases," without any further explanation, we are recommended to give 15-grain doses of salicin. This, the author states, splits up into carbolic acid and salicylic acid, which, when absorbed, "meet and destroy the pathogenic microbe," apparently whether present or otherwise. All the 17 or 18 prescriptions are stock formulæ, without the slightest claim to originality.

⁂

The second edition of a book on "The Hair and Its Diseases" has just been published by Messrs. Baillière, Tindall and Cox. Its author, Dr. David Walsh, has devoted a good deal of special study to this strangely neglected subject. His advice to general practitioners to acquire the elements of the subject is sound enough, for they would be thereby enabled in many instances to keep their patients from drifting into the hands of quacks. This little handbook is short and concise, but covers all the ground likely to be broken in ordinary practice. From a casual inspection it appears to register a considerable advance on the first edition, and to be well worthy of the general practitioner's attention.

⁂

It would be difficult to over-estimate the value of the "Index-Catalogue" of the library of the Surgeon-General's Office, United States Army, Vol. XII., Second Series, which has just reached us. Especially interesting must it be to those engaged in literary work, as it renders available the literature of modern medicine and enables the student to trace the evolution of scientific medicine. From the report of Surgeon McCaw, the librarian, we learn that the present volume contains 5,476 author-titles, 10,996 subject-titles, and 35,324 titles of articles in periodicals. So far as published, this great Index-Catalogue contains 290,862 author-titles, 367,104 book-titles, and 882,301 titles of articles in periodicals. But the mere enumeration of figures gives a very inadequate idea of the value of the work and of the obligation of the medical profession to the United States Government for their enlightened liberality in preparing and providing for the benefit of students such a stupendous, accurate, and practically useful publication, which in no niggardly spirit they bestow on the medical libraries of the world.

⁂

Messrs. Baillière, Tindall and Cox are announcing a particularly attractive and valuable set of new medical works. First of all we notice "Axenfeld's Bacteriology of the Eye," a standard book which has been translated by Dr. Angus Macnab. Then we have an important work on "Tropical Medicine," by Castellani and Chalmers, two authorities who have studied their subject first hand in hot climates. Freyer is represented by a volume on "The Surgery of the Urinary Organs." Major Herbert has a monograph on "Cataract Extraction," founded on extensive work in India. Kelynack contributes a volume on "Tuberculosis in Infancy and Childhood," a subject on which he is entitled to speak with authority. A practical book on "Operative Midwifery" has been written by Professor Kerr, of Glasgow; and "A Manual of Pathology," by Professor R. T. C. Leith, of Birmingham, is in the press, and a much-needed handbook on "Meat Inspection" is contributed by Dr. W. Robertson, Medical Officer of Health, Leith. Swan is the author of a note-book in the "Aids" series on "Genito-Urinary Diseases," and Turner publishes a "Pocket Osteology." Baker has a work on "The Spectroscope," and Gardner one on "Anæsthesia for Surgical and Dental Operations." This is a remarkably good record of new productions for a single firm.

REVIEWS OF BOOKS.

SURGICAL APPLIED ANATOMY (a).

This deservedly popular handbook is a marvel of compactness, and in its present form leaves little to be desired. Forty-three specially prepared figures have been added, and many of the others have been redrawn, while colours have been freely used to make the illustrations more effective. Surgical anatomy is not subject to fashion, and is less amenable to progress than certain other sciences germane to medicine; but wherever current views have been modified in deference to greater knowledge, the change has been duly embodied in the text. Well printed, and neatly and solidly bound, this little volume will certainly consolidate its hold on students of medicine.

NERVE DISEASES (b).

This is a very handy little guide to the study of disease of the nervous system, especially intended for the general student, only the commoner conditions, such as every medical student may expect to meet with, coming under consideration. After describing the essential features of the anatomy of the nervous system, which is, of course, an indispensable step to the comprehension of the pathological conditions, the author leads up to the methods of investigation, first general, then particular. In reading this little volume, we have been struck by the concision and lucidity of the author's literary style, and we do not remember ever having seen these morbid states and their phenomena described with such sobriety and plainness. It is to be feared that students are not infrequently discouraged by the extraordinary terminology and complexity that have seemed to be inseparable from this subject, but we recommend any such to invest in Dr. Clutterbuck's unpretentious little manual, which will assuredly give them a working familiarity with all diseases of the nervous system likely to require diagnosis at their hands.

(a) "Surgical Applied Anatomy." By Sir Frederick Treves, Bart., G.C.V.O., C.B., F.R.C.S.; Sergeant Surgeon-in-Ordinary to H.M. the King, Consulting Surgeon to the London Hospital, etc. Fifth Edition. Revised by Arthur Keith, M.D., F.R.C.S. Cassell and Co., Ltd. 1907.

(b) "Nerve Diseases." By L. A. Clutterbuck, M.D., B.S. (Durham); Hon. Physician St. Marylebone General Dispensary, etc. London: Scientific Press. 1907. Price 3s. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Vaginal Ovariotomy During Pregnancy.—Democh (*Monatsschrift für Geb. und Gyn.*, Bd. XXVI., Hft. 2) begins a paper on this subject with a review of the cases of ovariotomy per vaginam during pregnancy and during parturition which have already been recorded. He then describes a new case. The patient was a IV.-para in the second month of her pregnancy. A cyst the size of a child's head, and very adherent, lay behind the pregnant uterus, and being thus a grave danger during labour, it was removed by posterior colpotomy. The pregnancy was uninterrupted. The author concludes that in general the vaginal route is to be preferred for ovariotomy during pregnancy.
G.

Appendicitis During Pregnancy and During the Puerperium.—Stähler (*Monatssch. für Geb. und Gyn.*, Bd. XXVI., Hft. 2), having first described a case of appendicitis during pregnancy which he had observed, and having mentioned similar cases from the literature, comes to the following conclusions. Appendicitis, especially the severe forms, is rare during pregnancy and the puerperium. The causes of the origin of appendicitis during pregnancy are not different from the causes of origin during the non-gravid state. A greater liability to recurrence during pregnancy does not exist; at most as a result of the exertions of the uterus during labour old foci may be temporarily re-awakened. The author then describes the symptoms, the diagnosis, and the differential diagnosis of appendicitis during pregnancy. As regards the treatment, he advises early operation in acute as well as in acute recurring appendicitis in pregnancy. The proposal of some authors that the appendicectomy should be followed by immediate emptying of the uterus is in the author's opinion quite wrong. Drainage of the abscess cavity through the posterior fornix of the vagina, if such should be necessary, is not very dangerous, even though labour should come on, as a consequent infection of the uterine cavity has not been observed in any of these cases in which it has been performed.
G.

Hebosteotomy and its Position in Practical Obstetrics.—Leopold, at the 79th congress of the Deutscher Naturforscher und Aerzte (*Zentralblatt für Gynäk.*, Nr. 43, 1907), described his technique as follows:—With the patient under an anæsthetic and with the help of an assistant, a small stab is made through the skin down on to the pubic tubercle either on the left or on the right side of the symphysis. Through this Döderlein's needle is inserted and pushed from above downwards behind the os pubis under the control of the index finger in the vagina, so that the point of the needle appears between the smaller and the greater labia about a finger's breadth away from the angle of the pubic arch. The saw is now fitted to it, and when it has been drawn backwards the bone is sawn through. From his experience of over sixty cases Leopold comes to the following conclusions. The hebosteotomy is of most value when the conjugata vera varies from 6½ to 8 cm. The subcutaneous insertion of Döderlein's needle is best performed from above downwards. When there has been sufficient practice and experience of the operator injuries to the bladder are scarcely possible. After the hebosteotomy, which is only performed when the cervix is fully dilated, the uterus should be immediately emptied by either the forceps or version, according to the presentation of the child. Lacerations of the vagina must be carefully sutured. If the urine should be bloody a catheter must be kept in the bladder for several days. Leopold considers gonorrhœa to be a contra-indication to the performance of hebosteotomy, and advises instead the Porro operation, the extraperitoneal Cæsarean section, or even the perforation of the living child. Leopold considers that only an obstetrician who fully understands the operation and all its possible complications should undertake it, otherwise, when it is impossible to send the patient to a hospital, it would be better to perforate the child.
G.

The Relationship between Diseases of Women and Disease of the Intestine was discussed by Mueller (München) at the same congress (*Zentralbl. für Gynäk.*, Nr. 43, 1907). As a result of the inflammations of the intestinal mucous membrane, both mechanical and chemical, and of that produced by constipation, the development of intestinal polypi, intestinal ulcers, hæmorrhoids, periproctitis and periproctitic exudates and abscesses, parametritis, endometritis, ante-flexion and retroposition, retroversio and flexio uteri, parametritis and perimetritis atrophicans retrahens, pelvic peritonitis, perimetritis, and salpingo-oöphoritis is brought about. Through stenosis of the rectum, which is a result of posterior parametritis, catarrh of the large intestine, intestinal atony, sigmoiditis, left-sided oöphoritis and cystitis are produced. From the vermiform appendix arises salpingo-oöphoritis dextra, more rarely sinistra, pelvic peritonitis, etc. From the intoxication which is produced, chlorosis, rheumatism, gout, neurasthenia may result, or if already present, are aggravated. The treatment consists in warm applications and massage. It is important to obtain soft motions and through antiseptics, etc., to bring about healing of the diseased intestine. The author considers that it is wrong to believe that 90 per cent. of inflammatory diseases in the female are due to gonorrhœa; in his opinion 90 per cent. are due to the intestine.
G.

Thrombosis and Embolism after Gynæcological Operations.—Zurhelle read a paper on this subject at the same congress (*Zentralbl. für Gynäk.*, Nr. 43, 1907). Post-operative thrombosis is most frequently seen after myoma operations. The author saw it in 2.75 per cent. of all the myoma operations in the Frauenklinik Bonn. The cause is probably the chronic anæmia, the ergot treatment, and the other disadvantages of the palliative treatment when the heart has already been injured by the presence of the myomata. Next in frequency as a cause of post-operative thrombosis come the malignant tumours, when cachexia, ascites, etc., are present, marantic thromboses can be easily explained. For other gynæcological diseases, for example, tumours of the adnexa and displacements of the uterus, there are no special causes for thrombosis to be observed, but more general causes, for example, infection, cardiac changes, and anæmia. Other causes for this complication are the cooling of the abdominal cavity during laparotomy, injuries to the blood vessels, injury to the heart by the narcosis, obstruction to the circulation of the blood in the legs through tight compresses, meteorism, prolonged rest on the back, etc. The thrombosis is as a rule not due to one cause, but to quite a number of causes of which many work together. Better class patients are more liable to post-operative thrombosis than women of the working class. This is probably due to want of exercise, feeble circulation, want of muscle nutrition, and especially of the heart. There are three forms of thrombosis after gynæcological operations which are to be differentiated from one another:—(1) Thrombosis of the pelvic veins. The diagnosis is very difficult, and the condition very often produces pulmonary embolism, probably because the pelvic veins are without valves. (2) Thrombosis of the femoral vein, the most frequent form of post-operative thrombosis. It also leads to pulmonary embolism. It usually commences just underneath Poupart's ligament, or in the popliteal vein. It is generally a form of marantic thrombosis, and in the majority of cases is produced mechanically in cases of weak cardiac action. (3) Thrombosis of the saphenous vein, with reddening of the skin. On palpation this feels like hard cords and knots. This form does not produce pulmonary embolism. The author has never been able to prove from any of his cases the correctness of Mahler's observation that in a typical thrombosis chart a gradual rise of the pulse rate is to be found with a normal temperature. G.

Treatment of Peritoneal Wounds.—As the result of examination of a large series of cases, Pankow (*Monatssch. für Geb. und Gyn.*, Bd. XXVI., Hft. 2) concludes that cauterisation of the parietal or visceral peritoneum is followed by easy recovery of the peritoneal wounds as long as there is no hæmorrhage in the abdominal cavity, and that the formation of adhesions only occurs in exceptional cases. Wounds of the parietal peritoneum so severe as to produce diffuse points of hæmorrhage lead fairly often to adhesion formation. Healthy peritoneum affords the animal a greater protection against infection than that which has been injured and then treated with the thermocautery and absolute alcohol. The most unfavourable results are obtained when infection occurs in peritoneum which has been injured and not treated. In such cases adhesions are practically always formed. Consequently, during operation, all hæmorrhage should be controlled as far as possible, whether with the thermocautery or with absolute alcohol, in order that the danger of infection and of adhesion formation may be diminished. G.

The Scope of Treatment of Acute Pelvic Infections in Women by the General Physician.—Wesley Bovee (*Amer. Jour. Obst.*, October, 1907).—The writer's suggestions are, first, that the treatment of acute pelvic infections is, as a rule, not operative, but one of palliation and expectancy; second, that, practically, analgesics, other than the external application of ice, are not needed, and are harmful; third, that if surgical intervention becomes necessary during such acute stage of pelvic infection, it will be a simple procedure of vaginal incision and drainage, though extremely rarely will abdominal incision for this purpose be required; fourth, that a certain percentage of such infections result in symptomatic relief or cure by such palliative treatment. A very much larger proportion (the suppurative cases) will require operation, of which the vaginal incision and drainage, whether during the acute stage or later, will be sufficient, and when it fails radical surgery will have to be employed; and, fifth, that very rarely indeed will radical abdominal operation be required during the acute stage of pelvic infection. F.

Toxæmia of Pregnancy Relieved by the Administration of Thyroid Extract.—Fry (*Amer. Jour. Obst.*, October, 1907).—The patient suffered from headache, insomnia, and indigestion; the specific gravity of the urine had fallen to .1005, and the urea was less than one-half of 1 per cent. No albumen or casts were present. No change whatever was made in the diet or mode of living, but 5 grs. of thyroid were given t.i.d. The examination of urine made 36 hours after treatment was begun showed a rise of specific gravity .1018 and percentage of urea to 2.5. The above symptoms disappeared, and the tablets were then administered twice daily for some weeks. F.

Prolapsus Funis: A New Method of Treatment in Cephalic Presentations.—Stowe (*Surg. Gyn. and Obst.*) describes his new method, in which his idea is to try to restore the normal conditions of the first stage of labour by introducing into the uterine cavity normal saline solution to take the place of the liquor amnii and to provide a substitute for the membranes. Through a Voorhees bag, from base to apex, he has a separate rubber tube fixed without any connection with the interior of the bag, and when the bag is in position in the cervix, sterile salt solution is slowly injected into the uterine cavity. About one pint is generally sufficient. The cord is, of course, replaced before the bag is introduced and filled. The bags are made in two sizes. If there is very little dilatation of the os, the smaller one is used, to be replaced later on by the large one. When the larger one is expelled, the os is fully dilated, and immediate delivery by version can be done. If too much fluid is injected into the uterus, the pains will become very severe. Some of the fluid should then be allowed to escape. If there is much leakage by the side of the bag, fluid should be injected from time to time. F.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.

An ordinary meeting of the Council of the Royal College of Surgeons was held last Thursday, Mr. Henry Morris, F.R.C.S., President, in the chair. Eighty-seven candidates who had passed the required examinations and conformed to the bye-laws were admitted Members of the College (a complete list will be found under the heading, "Pass Lists"). No fewer than forty-two of these candidates were University students.

A letter from the deans of the medical faculties of the Universities of Leeds, Liverpool, and Sheffield suggesting the desirability of altering the times of year at which the primary examination for the fellowship of the college are held was read and referred to a committee for consideration.

The President reported that the Bradshaw Lecture would be delivered by Mr. Rickman J. Godlee, Vice-President of the College, on December 6th, at 5 p.m., and that the subject of the lecture would be "The Prognosis and Treatment of Tubercular Disease of the Genito-urinary Organs."

A report was received from the Museum Committee with reference to the appointment of a Conservator of the Museum. It was determined that the recommendations of the Committee should be further considered at the next meeting of the Council, on December 12th, and that the vacant appointment should be advertised after that date.

A letter was read from Dr. Liveing reporting that the appointment of Mr. Edmund Owen, F.R.C.S., as Visitor to the Egyptian School of Medicine for the examinations to be held at Cairo in December next had been confirmed by the Royal College of Physicians. It was determined to add Giggleswick School, Settle, Yorkshire, to the list of institutions recognised by the examining board in England for instruction in chemistry and physics, and Wyggeston School, Leicester, which is already recognised by the Board for instruction in chemistry and physics, was also recognised for instruction in biology.

THE DIRECT REPRESENTATION OF MEMBERS ON THE COUNCIL.

The Secretary announced the notices of motion for the annual meeting of Fellows and Members on Thursday, November 21st, at 3 p.m., to be as follows:—

To be moved by Mr. Frederick W. Collingwood: "That the President and Council of the Royal College of Surgeons be asked to use their moral influence with hospital authorities to recognise Members of the College (who are also in almost all cases Licentiates of the Royal College of Physicians) as having equal rights with provincial, Scotch, and Irish graduates to become candidates for hospital appointments."

To be moved by Mr. Joseph Smith: "That this twenty-third consecutive annual meeting of Fellows and Members again re-affirms the desirability of admitting Members to direct representation on the Council, which as now constituted does not represent the whole Corporation."

To be moved by Dr. W. G. Dickinson: "That this meeting regrets that the Council has omitted from their report any reference to the opinion of his Majesty's Government on the question of the representation of Members, and requests the President to supply the omission by communicating the same forthwith."

To be moved by Mr. George Brown: "That this meeting notes with satisfaction that the Council intends to take a poll of the Fellows and Members on the whole question of admitting women to the diplomas of the College, and this meeting further urges that a similar course be taken with regard to the proposal for direct representation of the Members upon the Council."

To be moved by Mr. H. Elliot-Blake (Bognor): (*a*) "That this meeting of Fellows and Members of the Royal College of Surgeons wishes the Council to report as to their willingness to join the Royal College of Surgeons and its work with the University of London (so as to form an Imperial University of London), and whether they will approach the Royal College of Physicians for a similar conjoint action." (*b*) "That this meeting requests the Council to add a hood to the gown already worn by Fellows and Members."

Royal College of Surgeons in Ireland.

NOTICE has been given of an alteration of some importance in the regulations respecting admission to the Fellowship. Hitherto candidates have been divided into two classes—those who are graduates or Licentiates in Surgery of over ten years' standing, and those who have held such diplomas or degrees for less than that period. In the case of the former no examination has been imposed in anatomy and physiology, as apart from surgery; the test which has been imposed in their case being known as Grade 2. After the date mentioned Grade 2 will cease to exist, and all candidates alike will have to pass under the scheme known as Grade 1. This entails examination in anatomy and physiology and histology and surgical pathology, as well as in systematic, clinical, and operative surgery. The alterations will take effect from January 1st, 1910.

The Cork Medical and Surgical Society.

THE annual dinner of this Society was held on November 9th in the Imperial Hotel, Cork. The President of the Society, Dr. Moore, occupied the chair. After dinner, the following toasts were proposed:—"The King"; "The Cork School of Medicine," proposed by the City High Sheriff, and responded to by Professor Corby and Professor Pearson; "Our Guests," proposed by Dr. Lee, replied to by Professor Molohan and Alderman Meade; "The City High Sheriff," proposed by Dr. Cotter. Professor Pearson also proposed the healths of the two newly-appointed professors at the Queen's College, Dr. Windle and Dr. Barry, and Dr. Barry, in the absence of Dr. Windle, replied. The last toast was that of the Honorary Secretary, Dr. Booth.

Irish University Education.

THE latest pronouncement on the subject of University Education in Ireland was made by the Chief Secretary for Ireland at the opening meeting of the Catholic University College Literary Society. In this connection Mr. Birrell, who was subjected to some cross-questioning, said: "All I will say is that I believe that that question can be, and ought to be, and, please God, will be, solved in the next session of Parliament. I know no cause to which I would more willingly devote my life, and I know no cause in which I would more willingly suffer political extinction, than the cause of securing for the Irish people that higher education which justice demands that they should have, which it is imperatively necessary that they should have if they are to discharge the important duties already imposed upon them, and the still more important duties which cannot long be withheld from them. This battle will be a hard fight. Opposition there will be, I doubt not, both in Ireland and in England, to any such measure as I hope to be able to propose. . . . It can only be done by general support, by sympathy, and by feeling. I, at all events, pledge myself to do the very best that mortal man can do in this next session of Parliament, and if I fail, why then, gentlemen, I can promise you this—that you will be troubled with me no more."

Mr. Birrell has not as yet divulged the nature of the solution which he intends to offer for this long-standing question, but many things point to a probability of a rearrangement of the Royal University, either with or without the establishment of local Universities in Belfast and Cork. Our Belfast correspondent, in the present issue of this journal, refers to the growth of a feeling in Belfast in favour of a separate University, but there is at the same time in that city a strong body of feeling which opposes what it believes would be a University under the control of Presbyterian clerics. Mr. Bryce was dogmatic, and he failed. Mr. Birrell is optimistic, and there are many who hope that he will succeed, if, and only if, his sole end is the improvement of higher education in Ireland.

Devon Medical Man's Divorce.

IN the Divorce Court, on November 13th, Dr. William Pitt Palmer, of Babbacombe, Devon, was awarded a decree nisi and £2,000 damages on the ground of his wife's misconduct with Major Charles Barchard. There was no defence.

Mr. Willock said the marriage took place at Torquay on June 5th, 1895, the petitioner residing at Torquay. One son was born, in April, 1896. The co-respondent described himself as a retired major of the West Yorks Regiment. The petitioner strongly objected to his wife associating with the co-respondent. Mrs. Palmer began to neglect her home, and was frequently excited through drink. She went away from home, and would not give any explanation as to where she had been. He found she spent Christmas Day, 1906, at the co-respondent's house.

Dr. Palmer subsequently received a letter from the co-respondent posted in Bristol, in which he threatened to take proceedings against Dr. Palmer for defamation of character in alleging that he and the respondent had stayed as man and wife at Charing Cross Hotel. A few days later came a telegram from Major Barchard. Upon receiving this message the petitioner and his brother went to Bristol, and found the respondent and co-respondent together. Afterwards the respondent and co-respondent went to another address in Bristol, staying together as man and wife, the co-respondent finally going away, leaving the respondent at the place. Dr. Palmer filed his petition, and the co-respondent, not having insulted him enough, sent him a postcard:—

"Am in receipt of citation for divorce *re* your wife and yourself. As I do not intend to take all the responsibility on my shoulders, I shall cite others. I shall also prefer charges of collusion, cruelty, and neglect."

The petitioner gave evidence of his wife's relations with Major Barchard.

The Judge, in summing up, said he could hardly remember a case where the conduct of the co-respondent had been so serious.

The jury awarded £2,000 damages, and his lordship granted the petitioner a decree nisi, with costs, and the custody of the child.

Limerick Union Medical Officership Election.

IT is stated that the authorities, acting on the representation of the Local Government Board, have ordered the prosecution of some 16 persons, who, as alleged, were concerned in the election of Resident Medical Officer of Limerick Workhouse several months since, and respecting which election a sworn inquiry was opened in the month of June, and continued on various dates. It is further stated that the charge will be one of conspiracy and corrupt practices, and that the summonses will be served in the course of a day or two.

Interesting Workmen's Compensation Case.

BEFORE Judge Willis, K.C., in the Southwark County Court, on November 4th, an action was brought by Frederick Reeves, a shield driver, against Messrs. Price and Reeves, contractors, to recover damages under the Workmen's Compensation Act.

Counsel for plaintiff said the latter in May last was working for the respondents in Rotherhithe Tunnel, when, in passing from one stage to another, he slipped from a plank and fell upon a man who was using a large spanner. Plaintiff's jaw struck the spanner, and he subsequently went to the London Hospital, where an operation was performed upon him, a portion of his jaw-bone being removed. On July 29th he returned to work and continued working until August 19th, when he was compelled to again go to the hospital, and had been unable to work since. Counsel added that cancer supervened, and the plaintiff had to have a portion of his tongue cut away. The respondents contended that the formation of cancer in no way resulted from the accident, but the plaintiff's case was that it was directly due to it.

Several doctors gave evidence for and against the plaintiff's contention that the blow caused the cancer.

His Honour came to the conclusion that the cancer did result from the blow, and he ordered the plaintiff to be paid £1 per week during the time he remained incapacitated.

Cape Doctors Censured.

A SPECIAL meeting of the Cape Colonial Medical Council was held recently, at which there were present:—Dr. C. F. K. Murray (President of the Council), Sir Edmond S. Stevenson, Dr. Darley Hartley, Dr. Wood, and Dr. Johnston, with Advocate J. T. Molteno, legal adviser to the Council. In the case of Dr. McMullen, who was charged with having prescribed opium for purposes other than *bonâ fide* medicinal purposes, and in which judgment on a former occasion had been reserved, it was notified that the Council had found Dr. McMullen guilty of "infamous and disgraceful conduct in a professional respect." A similar charge was preferred against Dr. Frederick R. Kruger of Cape Town, and he was found guilty of "improper and unprofessional conduct," and reprimanded accordingly.

The Mineral Water Hospital, Bath.

THE Governors of this ancient charity have found it necessary to decrease the number of beds owing to lack of funds. The hospital is really a national institution, being very little used by patients from Bath itself owing to the intentions of the original Founder. Of the 149 inmates at present in the building, 148 come from other towns, cities and rural districts throughout the British Isles, and the Hon. Treasurers feel that they are justified in appealing for national help at the present juncture. Most other hospitals are largely supported by annual subscriptions; but in consequence of the liberality of this institution in admitting patients without subscribers' recommendations, it is to a great extent deprived of that source of income, the total annual subscriptions received last year from private persons being only about £600. We trust that this appeal, which is made officially by the Mayor of Bath, will meet with the success it merits.

The Irish Medical Schools and Graduates' Association.

THE autumn meeting and dinner of this Association will be held at the Hotel Cecil on Wednesday, November 27th, at 7.30 p.m., when the special guests will be Sir James Digges La Touche, K.C.S.I., and Sir Shirley Foster Murphy.

Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society, was held in London on the 8th inst., Dr. de Havilland-Hall in the Chair. The accounts presented showed that the business of the Society continued in a very satisfactory condition. During the summer months the sickness claims had been somewhat in excess of the expectation, but during the month of October they were few in number, and for the most part of short duration. A small addition has been made to the list of those permanently incapacitated, and so drawing what are practically life annuities, but not more than was expected from the growing number and increased age of the members. Prospectuses and all further particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London.

THE opening meeting of the Dublin University Biological Association will be held to-morrow evening, when the President, Dr. Robert J. Rowlett, will deliver an address on "Biology and Therapeutics." Among the speakers will be Sir Arthur Chance, Drs. W. St. C. Symmers, Walter G. Smith, and J. B. Coleman.

THE Earl of Rosebery presided at a quarterly meeting of the trustees of the Hunterian collection, held at the Royal College of Surgeons on November 13th. Sir Douglas Powell (President of the Royal College of Physicians), Mr. Henry Morris (President of the College), and Dr. David Ferrier, Dr. J. Mitchell Bruce, and Professor G. Sims Woodhead were present at the meeting. Sir John Tweedy was elected a trustee of the collection in the vacancy occasioned by the decease of Sir Joseph Fayrer. The trustees adopted a resolution expressing regret at the death of Professor Stewart, and recorded their appreciation of his services as conservator of the museum.

LORD BALFOUR OF BURLEIGH recently attended a meeting at Birmingham in support of the scheme for providing the Queen Alexandra Sanatorium at Davos. His lordship said the object was to provide accommodation for English-speaking patients of small means suffering from curable forms of pulmonary disease. The site had been purchased, and a large sum raised, but £15,000 to £16,000 more were required. Sir Oliver Lodge proposed a resolution commending the sanatorium to the sympathy and support of the public, and it was decided to open a fund in the town.

PASS LISTS.

Royal College of Surgeons.

THE following candidates, having passed the required examinations and conformed to the bye-laws, have been admitted members of the Royal College of Surgeons of England:—

Wm. S. Alderson, M. Thos. Ascough, Wm. Thos. Briscoe, B.A., Arthur Burrows, Martin Camacho, Jas. R. C. Canney, B.A., J. A. Clark, Robt. M. Coalbank, J. L. Cock, G. G. Collet, B.A., Wm. W. Cook, Robt. Crawford, B.A., N. C. Davis, G. H. Davy, B.A., E. J. de Verteuil, R. L. E. Downer, G. W. Dryland, B.A., N. A. Eddlestone, E. P. Evans, F. P. Fisher, A. E. Foerster, A. E. G. Fraser, T. R. Glynn, B.A., P. H. G. Gosse, Morrice Greer, J. E. Hailstone, M.A., J. P. Hastings, H. J. Henderson, E. B. Hinde, B.A., F. G. Hitch, E. Le R. Hodgkins, M. J. Holgate, F. H. Holl, J. G. Ivers, W. M. Jeffreys, B.A., Robt. Knowles, B.A., Percy Lang, A. N. Leeming, K. A. Lees, B.A., W. H. Leigh, R. McC. Linnell, B.A., H. N. Little, B.A., E. W. Lowry, J. A. Master, W. L'Estrange Mathews, M. H. E. R. Montesole, Benj. Moore, H. H. Moyle, A. T. Nankivell, W. F. Neil, Donald North, E. E. T. Nuthall, B. H. Palmer, B.A., John Parkinson, D. G. Perry, C. H. L. Petch, A. G. Peter, L. L. Phillips, Montagu Phillips, B.A., E. S. Phipson, M. D. Price, M. J. Rattray, Alfred Richardson, C. M. Rigby, C. F. Robertson, L. P. Sanders, E. A. Saunders, S. MacK. Saunders, G. B. Scott, R. B. S. Sewell, B.A., F. M. Smith, P. L. Stallard, B.A., R. H. E. Stevens, K. H. Stokes, H. D. Thomas, G. G. Timpson, S. N. Tiwary, G. W. Trigg, B.A., R. W. S. Walker, B.A., G. D. H. Wallace, A. L. Walters, W. W. White, Reg. Willan, R. T. Williams, G. E. Wilson, A. L. Yates, and A. P. Yonge, B.A.

A Diploma of Fellow has been granted to Lieut. R. H. Bott, I.M.S., and Diplomas for Licence in Dental Surgery to E. W. Cooke and D. B. Franks.

Royal College of Surgeons in Ireland—Dental Examination.

THE following candidates have passed the necessary examination for the Licence in Dental Surgery:—P. J. Bermingham, T. J. K. Bradley, C. J. Hyland, F. Leniham, M. S. Philson, and R. P. Thomson.

The following have passed the primary part of the examination:—W. Bennett, N. A. Clarke, C. A. Furness, and L. P. Vernon.

Trinity College, Dublin.

THE following candidates passed the Final Medical Examination, Part II., Michaelmas, 1907:—Medicine.—William S. Thacker and George F. Graham (passed on high marks); Frank R. Seymour, Bethel A. H. Solomons, Edward C. Stoney, Edward J. H. Garstin, Julian B. Jones, Henry J. Keane, William H. Sutcliffe, William Knapp, John H. Waterhouse, Albert E. Wynne (*satis respondit*).

NOTICES TO CORRESPONDENTS, &c.

☛ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

M. R. S.—The mortality, direct and indirect, of acquired syphilis, when properly treated, is stated not to exceed 4 or 5 per cent. These figures apply to normal and otherwise healthy individuals, of regular habits. In elderly, inebriate, and exhausted subjects the proportion is probably tenfold. It is obvious, in view of the difficulties inherent to such researches, that the statistics can only be very approximative.

METRICUS.—It may interest you to know that the English penny piece weighs exactly ten grammes and the halfpenny five grammes. Inasmuch as an ounce is approximately the equivalent of thirty grammes, three pennies may be taken to represent one ounce and so on.

MINOR.—We should not recommend our correspondent to consent to the clause mentioned in the partnership deed.

COMA.—Many things have been tried, but we think the only treatment for diabetic coma which has shown any particular result is the administration of sodium bicarbonate. The drug may be given by mouth or by hypodermic injection, preferably the latter. The theory on which it is given is that of excess of acid (chiefly β-oxybutyric acid) in the blood.

W. R. M.—The statement you refer to is one of the standing type that find their way into medical text-books, and then become stereotyped by being adopted by one author after another. No one quite knows how they arise. We should be very sorry to defend it ourselves.

INCOME TAX REMISSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—By the Finance Act, 1907, passed in the last session of Parliament, the 133rd Section of the Income Tax Act, 5 and 6 Vict., c. 35 (whereby relief was granted whenever the profits of the year of assessment fell below the average) was abolished. All persons who shall receive a notice of charge for the current year (1907-8) desiring to appeal against the same on the ground that it is excessive, are required to give notice of appeal within the time set out on such notice of charge, failing which the Commissioners of Taxes will not at any time thereafter entertain any application to have such assessment amended. Persons whose profits for the year ended prior to the 6th day of April last fell below the average should at once take the necessary steps to claim repayment of any sum they are entitled to.

Yours, etc.,
THE INCOME-TAX ADJUSTMENT AGENCY.
E. MONTAGUE,
Sec.

London, E.C.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 20TH

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m.: Paper:—Mr. J. W. Gordon: Mercury Globules as Test Objects for the Microscope.

ROYAL METEOROLOGICAL SOCIETY (Institute of Civil Engineers, Great George Street, Westminster, S.W.).—7.30 p.m.: Papers:—The International Balloon Ascents, July 22nd to 27th, 1907. Reports by Mr. W. H. Dines, Mr. J. E. Petavel, Mr. W. A. Harwood, Capt. C. H. Ley, and Prof. W. E. Thrift. Discussion of the Meteorological Observations made at the British Kite Stations, 1906-1907 (Miss M. White, Mr. T. V. Pring, and Mr. J. E. Petavel).

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m.: Inaugural Address: Sir Steuart C. Bayley.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. R. Johnson: Clinique. (Surgical.) 5.15 p.m.: Lecture: Mr. D. Armour: Head Injuries.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

THURSDAY, NOVEMBER 21ST.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. A. W. M. Robson: Pancreatic Catarrh and Interstitial Pancreatitis in Relation to Catarrhal Jaundice and also Glycosuria.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Throat Operations (Mr. Carson). 5 p.m.: Demonstration at the Mount Vernon Hospital, Hampstead, N.W.:—Dr. J. E. Squire: Selected Chest Cases.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—8 p.m.: Chesterfield Lecture:—Dr. M. Dockrell; Acne Vulgaris in its Three Stages: I., Comedo; II., Indurata; III., Necrotica.

HOSPITAL FOR SICK CHILDREN (Gt. Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. Kellock: Torticollis.

FRIDAY, NOVEMBER 22ND.

ROYAL SOCIETY OF MEDICINE (EPIDEMIOLOGICAL SECTION) (20 Hanover Square, W.).—8.30 p.m.: Paper:—Dr. M. Coplans: Medical Inspection in Schools: The Gloucestershire Scheme.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. H. Tilley: Clinique. (Ear.) 5.15 p.m.: Lecture:—Dr. D. Ferrier: Atrophic Paralyses.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Outpatient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Demonstration:—Dr. W. Wingrave: Clinical Pathology.

TUESDAY, NOVEMBER 26TH.

ROYAL SOCIETY OF MEDICINE (THERAPEUTICAL AND PHARMACOLOGICAL SECTION) (Apothecaries' Hall, Blackfriars, E.C.).—4.30 p.m.: Dr. James Cantlie, M.B., F.R.C.S.: Some Tropical Diseases and the Remedies Required for their Treatment and Prophylaxis; Dr. William Murray, F.R.C.P.: Therapeutics of Indigestion.

Appointments.

EVERSHED, A. R. F., M.R.C.S., L.R.C.P.Lond., Honorary Ophthalmic Surgeon to the Brixton Dispensary.

HOLLAND, EARDLEY L., M.D. Lond., F.R.C.S.Eng., Obstetric Registrar and Tutor to King's College Hospital.

INNES, JOHN, M.B., C.M.Aberd., Medical Officer to the Aberdeen Dispensary.

M'EWAN, THOMAS DUNCAN, M.B., Ch.B.Glasg., Junior Assistant Physician to the Royal Asylum, Glasgow.

READ, A. W., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Chelsea Hospital for Women.

SHAPLAND, JOHN DEE, M.D.Durh., Honorary Medical Officer to the Brixton Dispensary.

SHAW, CHARLES JOHN, M.D.Edin., Senior Assistant Physician to the Royal Asylum, Glasgow.

Vacancies.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer. Salary, £140 a year, with board, lodging, etc. Applications to Medical Superintendent.

Shanghai Municipal Council.—Assistant Medical Officer of Health. Salary, £580 per annum. Applications to Messrs. John Pook and Co., 63, Leadenhall Street, London, E.C.

Windsor and Eton Royal Dispensary and Infirmary.—House Surgeon. Salary, £110 per annum, with residence, board, laundry, and attendance. Applications to Geo. P Cartland, Secretary.

West Riding Asylum, Wakefield.—Assistant Medical Officer. Salary, £150 per annum, with apartments, board, washing, and attendance. Applications to the Medical Director.

Royal National Hospital for Consumption for Ireland.—Resident Medical Officer. Salary, £300 per annum, with house. Applications to Hon. Secretary, 13, South Frederick Street, Dublin.

Births.

JOBSON.—On Nov. 11th, at Trelyon, Ilford, the wife of T. Battersby Jobson, M.D., of a daughter.

SOMERSET.—On Nov. 12th, at Stoneleigh, Mansfield Road, Reading, the wife of Edward Somerset, M.R.C.S.Eng., L.R.C.P. Lond., of a son.

SYMONS.—On Nov. 14th, at Officers' Quarters, Queen Alexandra Military Hospital, Millbank, S.W., the wife of Major F. A. Symons, R.A.M.C., of a daughter.

WISE.—On Nov. 14th, at 206, Burrage Road, Woolwich, the wife of H. M. Wise, M.B., of a son.

Marriages.

DENT—LEWIS.—On Nov. 15th, at St. Peter's Collegiate Church, Wolverhampton, Howard Henry Congreve Dent, F.R.C.S., eldest son of the late Joseph Henry Dent and Mrs. Dent, of Merivale, Edgbaston, to Olive Mary, daughter of Rowland W. Lewis, J.P., of Penn Croft, near Wolverhampton.

GIBBINS—DIX.—On Nov. 18, at St. James's, Paddington, Kenneth Mayoh Gibbins, M.B., B.S.Lond., M.R.C.S., L.R.C.P., of Holmdale Parkstone, Dorset, eldest son of B. T. Gibbins, of Ilkley and Tunbridge Wells, to Anne Mary, daughter of the late Thomas Tucker Dix, of Wells, Somerset.

TOOTH—CHILVER.—On Nov. 12th, at the Parish Church, Midhurst, Howard Henry Tooth, M.D., C.M.G., of 34, Harley Street, London, to Helen Katharine, second daughter of the Rev. Charles S. Chilver, of Gate House, Midhurst.

Deaths.

COOKSON.—On Nov. 12th, at St. Kitts, Carysfort Road, Boscombe, Jane Grace, wife of Samuel Cookson, M.D., late of Stafford.

HUTCHINSON.—On Nov. 15th, in London, after a long illness, Sir Charles Frederick, M.D., of Mayfield, Sussex, youngest son of Dr. Hutchinson, of Nottingham and Scarborough, in his 58th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, NOV. 27, 1907. No. 22

NOTES AND COMMENTS.

The "Brown Dog" and the Students. THE news of the raid on the "brown dog" memorial at Battersea by some University College and Middlesex Hospital students, and its disastrous termination, is very poor reading, as likewise are the accounts of the subsequent demonstrations and processions. It is of course not legal, and therefore not politic, to smash property that does not belong to one, however offensive such property may be. The law will not even allow a sanitary authority to break up the most pestilential doss-house without full compensation to the owner out of the ratepayers' pockets; it matters not that his property has been a cause of sickness and death to dozens. So, too, it is possible apparently to write on an erection in a public place an insult to a learned corporation, calculated to bring it into disrepute and contempt, and to enjoy the full protection of the law. It is difficult to believe that the Council of the University College have not taken legal advice on the matter, and been advised to let it rest; but we should have thought ourselves that taking the words of the inscription and the action of the erection of the memorial very good grounds for a libel action are shown. The dog is alleged to have been "done to death in the laboratories of University College," and though the phrase may possibly not bear an exact legal interpretation, it is always used as a synonym for murder. Murder is illegal killing, and whatever may be said about the dog's death it was destroyed in a perfectly legal and regular manner. That, to our mind, might constitute one count in a libel action. The second is like unto it. It is said the dog "endured vivisection extending over more than two months." The *suggestio falsi* is obvious enough. We should go further and say that the ordinary interpretation of the words would be that the animal was operated on continuously for two months, which, though absurd to instructed persons, would not be to the folk likely to see most of the memorial.

Its Serious Side. IT may be wise of University College to take no action if not assured of winning on legal grounds, but it is impossible for the Council to be surprised at its students feeling and resenting the insult. They must also remember that the London newspapers, which regard undergraduate "rags" at Oxford or Cambridge as pardonable youthful frolics, even if a policeman or two be maimed seriously, always characterise in the harshest terms any evidence of similar spirit in a London student. The Battersea memorial is a standing menace to the reputation for good conduct that London medical students have earned for themselves for the last twenty or thirty years, and the point is one for the authorities fully to consider. The whole "brown dog" incident constitutes one of the most disgraceful pages in the anti-vivisection movement, and that we fear only because it happened to be sifted in a court of law. The story was a grave perversion of facts; it was repeated to a large audience without inquiry or confirmation, and was disproved before a jury. Without one word of regret for the utter want of truth and ingenuousness characterising the whole affair, the anti-vivisectionists subscribed £2,000, the amount of the damages rewarded for the libel, to recompense the defendant, and actually proceeded further to accentuate their want of shame by erecting a memorial to commemorate the incident. It is bad enough that a section of faddists should behave thus, but that the official representatives of a London borough should receive the statue especially bearing such an inscription is almost incredible.

Vice-versa. WE wonder how the young men of Battersea, who take a pride in their borough and their civic representatives would like it if (say) University College erected in Gower Street a monument to a bullock, with some such inscription as the following:—

"In memory of the dun bullock, which was cruelly mutilated by being castrated, without any anæsthetic, in order that his flesh might taste better at the Mayoral dinner at Battersea in November.

"Also in memory of 5,000 bullocks done to death in Battersea every year for the gratification of man."

We hope that they would have sufficient good feeling not only to resent the insult, but to recognise that, whereas the barbarous operation was performed not only without anæsthetics but for no necessary purpose, that animal experimentation provides the children of their borough with the only means whereby they can efficiently be helped to recover when attacked by diphtheria. At any rate, we could hardly be astonished if demonstrations in force were made against such a memorial, and we suspect that those journals who regarded the suffragette riots with amiable tolerance, and now denounce the students with corresponding vigour, would find plenty of excuses in "provocation."

"Self-Protection." SINCE the days of Madame Blavatsky and Mr. Edmund Garnett's revelations there has been a great slump in Indian mysteries and cults, and our American friends have taken the opportunity to foist a little occidental philosophy upon us in the shape of Christian Science. The essence of both cults seems to be unlimited credulity, and (at least) a moderate income. The poor, however little their education, curiously enough are seldom effected by these typhoons of ecstaticism, whether they blow from East or West. But on the stage of esoteric things enters a fresh heroine, a Hindoo lady, bearing the very Eastern name of Madame Cavalier, who seems destined to win fame again to her neglected country. Recently she gave a lecture on the very original title of "Self-protection from Adverse Suggestions." From the description of the lecture it seems that she started away with the usual preamble about earth-planes and spirit-spheres, but the cloven hoof soon exhibited itself beneath the silk gown, and the full tide of doctors not knowing their own business and Madame Cavalier knowing a great deal about it, was let loose. The adverse suggestians from which people are to protect themselves, are not, apparently, those thrown out by Madame Cavalier, but diseases. It is true, says the prophetess, you suffer pain—there, at least, she has the start of the Christian Scientists, for people always like others to know when they suffer—but you can always get rid of it by calling only on the "leader." The leader may be Mahomet or Christ; it really does not matter; they will be effectually protected by an "electric band of light." The room is said to have been filled with devotees, and we shall probably soon have a church, temple, or mosque erected for their convenience.

Alcohol and Cirrhosis.

It is a curious fact that it needed the excited comments of the lay Press on two cases of hepatic cirrhosis in children to stir the medical profession to look up the evidence connecting that condition with alcoholic excess. At any rate, the attention of the profession has been seriously directed to a scientific question as the result of outside agitation. Whatever may have been in the minds of most, Dr. Welsh Branthwaite's intimation that among 8,000 drunkards with whom he has been brought into contact during the last five years, he has never come across one case of cirrhosis, is a little disconcerting. Dr. Branthwaite says he has seen congestive liver enlargement and functional disturbance after drinking bouts, but they have always subsided under rest and temperance. It is probably true that only a small proportion of drinkers get cirrhosis, and that cirrhosis is not only caused by alcohol, but it may seriously be questioned whether it be actually alcohol itself or some other constituent in intoxicating drink which causes the fibrosis. The attention directed to the subject will do much good if it result in clearing up the enigma, but as an instance of the harm that the questioning of a belief like this may do we may instance an article in the *Daily Telegraph* of November 18th, in which the writer uses the discussion to show that alcohol may not be such a bad thing after all, and that it is unreasonable to attempt to limit the supply of drink to people till more is known about it. Happily, even people who are not doctors recognise that alcohol has some dangers, even if cirrhosis of the liver is not the most prominent.

LEADING ARTICLES.

DO MEDICAL MEN ASSIST IN THE SALE OF PROPRIETARY MEDICINES?

The mind of the medical profession, as a whole, is sufficiently well made up on the point of the evil of proprietary medicines to warrant some plain speaking as to the matter. In approaching such a subject it becomes at once apparent that many diverse interests are concerned, and that there are manifold phases which demand careful investigation in order to arrive at anything like a sound perception of their relative meaning. The truth of that proposition will be readily recognised after a brief survey of the operations of the drug trade, both wholesale and retail, of the proprietary medicine trade, of the professional journals and publications, of the newspapers and journals that profit by advertisements, of all these as regards capitalists, public and medical profession. The tangled issues involved in that combination present a problem that requires tact, knowledge, and a strongly judicial spirit for its solution. Among these complexities arises the question whether medical men do not in some instances play into the hands of the proprietary system which they regard with so much disfavour. This doubt has been sugested by an important work recently issued by the Pharmaceutical Society of Great Britain, under the title of the "British Pharmaceutical Codex." The scope of the volume may perhaps best be conveyed to medical readers by designating it as a kind of enlarged and comprehensive extra-pharmacopœia. Its appearance has given rise to a vast deal of criticism in the ranks of the pharmacists themselves. We are not here concerned with the list of inaccuracies inevitably connected with a work of so great dimensions, dealing as it does with a vast array of details. Nor does there seem great pertinency in the complaint that the volume in question to a great extent partakes of the nature of a compilation. So far as the medical profession is concerned one of its most important features consists in the definition of a great number of drugs or combinations of drugs sold under fancy names, so that any practitioner can, by reference to the Codex, see exactly what he is ordering, and, if necessary, replace it by the corresponding drug from the British Pharmacopœia To take an instance which is unlikely to injure delicate susceptibilities, it is well known that boracic acid forms the basis of various dusting and face powders, sold under a variety of catchpenny titles. Let us for a moment assume that a medical man entertained the unlikely intention of prescribing one of those proprietary dusting powders. By turning to the particular trade name in the Codex he would at once learn that it consisted of, say, boracic acid, starch, and oxide of zinc, whereupon he might write his own formula. It may be argued that he would be doing an injury thereby to the proprietor, but it is difficult to understand what exclusive right can be claimed in a combination of well-known drugs, such as are ordered by medical men daily throughout the length and breadth of the land. It would be easy to multiply instances almost indefinitely, but it will serve the purpose if readers are asked to think for a moment of the various proprietary forms in which aloes, jalap, permanganate of potash, cascara sagrada, the salicyl compounds, chloral and opium are sold to the public. We suggest that medical practitioners who order such compounds are playing into the hands of the traders in proprietary medicines. The position of the Pharmaceutical Society with regard to the matter may be gathered from the following quotation, taken from the preface to the Codex. "Special attention has been devoted to the nomenclature of substances of definite composition which are known under a variety of names, and it has been considered desirable to describe such substances under brief, more or less descriptive names, which have, in some instances, been specially devised for the purpose. Reference is made to trade-protected names and other commercial designations of such substances in footnotes to the respective monographs, though prescribers will prefer to encourage the use of names which everyone is free to use. Trade names, as a rule, can only be legally applied to the products of firms or individuals in whom proprietary rights in those names are vested, and the attention of dispensers is particularly directed to the fact that when a medicament is ordered under a proprietary trade name, it is not permissible to substitute a similar product to which that trade-name does not legally apply." The subject is alive with possibilities, and medical men will do well to inform themselves upon the prescribing of simple drugs under fancy names thus brought within the range of practical politics by the issue of the Codex.

CLIFFORD v. TIMMS.

The last phase of Clifford v. Timms was completed in the House of Lords last week, when the Court, consisting of the Lord Chancellor, Lord Halsbury, Lord Macnaghten, and Lord Atkinson, gave judgment for the respondent without even calling on his counsel. We can only say that if the House of Peers gave equally convincing proof of its business acumen in political matters, there would be little demand for its reform from either party in the State. To the non-legal mind it has always been a marvel how any lawyer could have advised that there was any ground for action, the breach of the partnership agreement being so obvious and above board. But the marvel was rendered still more staggering when the case was heard before Mr. Justice Warrington, and decided against the defendant. At the trial a great deal was done to "side-track" the issue by raising the unnecessary question as to whether the decisions of the General Medical Council are binding on other statutory authorities, and it must be confessed that it is a pity that the House of Lords could not have settled the matter once for all in giving their judgment. We have no reasonable doubt what the decision would have been after the views that were expressed in the Court of Appeal, although Mr. Justice Warrington in the lower court, in our opinion, erred strangely for a man of his calibre. But although, as we say, we regret the point was not settled by the House of Lords, we commend heartily the broad outlook taken by their lordships and the business-like way in which they refused to be drawn by the red herring dragged across their path. The whole point of the case was whether the action of Mr. Clifford, in starting an institute of dentistry, worked by unregistered dentists under the supervision of himself and his family, who were registered dentists, and advertising the institution by such methods as decrying the competency, and even making insinuations against the characters of English dentists, was guilty of professional misconduct, because, if so, Mr. Timms was at liberty to break his partnership deed. This exceedingly simple issue led to all this litigation and fuss, when to the ordinary man it must have been palpable that if professional misconduct, as apart from private misconduct, means anything, it means precisely conduct of the character perpetrated by the appellant. The Lord Chancellor, in giving judgment, in which all the members of the court concurred, brushed aside the question of the statutory authority of the decisions of the General Medical Council as being a matter of indifference to the issue, and merely said that it having been shown that Mr. Clifford had sanctioned the form of the advertisements, professional misconduct was *ipso facto* proved. We heartily congratulate Mr. Timms, and trust that now he has severed himself from these gentry, he will enjoy the pursuit of his art by the regular methods which all that is best in the spirit of dentistry seeks to establish in the practice of that beneficent art.

CURRENT TOPICS.

The Victory at Bristol.

The determined and united action of the Staff of the Royal Infirmary at Bristol and the practitioners of the neighbourhood has met with the success that must always follow such action, namely, by the withdrawal of the propositions of the other side. We understand that the settlement has been arrived at by a process of give and take, and the terms will probably be announced in due time. But the matter for rejoicing at the present moment is that it has been demonstrated again that no town or country can afford to flout medical opinion, and that if medical men are firm, reasonable, and united they cannot be overridden by any body in the land. The victory is especially gratifying in that most of the committee of the Royal Infirmary are strong men of much local prestige, and the issue was one which offered considerable temptations to such medical men as did not see eye to eye with their colleagues in the matter. But in all these matters it must be borne steadily in mind that the undermining of the influence of a colleague or band of colleagues is a dangerous policy which is sure sooner or later to react on the interloper. Happily in the present instance there has been nothing but loyalty, and the staff have vindicated their right to be regarded not as subordinates to the Committee of Management, but as their colleagues and coadjutors. The staff would not have dreamed of laying down how many charitable committees members of the Board might serve on; it was no less ridiculous for the Committee to attempt to lay down a similar rule for the staff.

The Memorandum of the Medical Department of the Board of Education.

The Board of Education, through the Medical Department, have issued the promised memorandum on the medical inspection of school children. As we have indicated before, the policy of the Board as now more definitely declared, is to work the inspection through the medical officer's of health department, and, according to the memorandum, he is to be the chief executive officer, having such assistants and subordinates as his authority thinks necessary. The practical and economical convenience of this policy is obvious; its dangers equally so. Let us hope that in practice the latter will prove below expectation. The words of the memorandum are brave and, we are sure, sincere. "One of the objects of the new legislation is to stimulate a sense of duty in matters affecting health in the homes of the people; to enlist the best services and interest of the parents; and to educate their sense of responsibility for the personal hygiene of their children. . . .

It is in the home, in fact, that both the seed and the fruit of public health are to be found." All that is as it should be, but if this process of enlistment and stimulation is to be successful, it will require an amount of patience and tact among the officers appointed which are very personal to the individual. The Board have decided to have but three inspections of the children—namely, on joining, at about the third year after joining, and at about the sixth year after joining; and they hope that the parents will be present at the first inspection. We fancy that the last suggestion is one of the most salutary.

The Medical Student of To-day.

Curiously enough, only a few days have elapsed since the appearance in our columns of a comment upon the docile and exemplary conduct of the medical student of to-day. Within the past week some extraordinary ebullitions have taken place in London, arising out of a police-court prosecution of certain medical students, the facts of which are noted elsewhere. The demonstrations have been of an innocent but somewhat tumultuous nature. Members of various schools have rushed in shouting procession through the streets, bearing in one instance the figure of the Highlander taking snuff, which has appeared on previous occasions, and in another instance carrying aloft an effigy of the unpopular magistrate. Such conduct is indefensible, if only on the ground of the potential disorder of a serious kind that is inseparable from emotional outbreaks of this kind conducted *coram publico*. At the same time it will hardly be denied by police and public that some ground of provocation was altogether wanting in the affair. Indeed, the whole demonstration may be regarded as the harmless protest of a number of high-spirited youths, who imagined they were labouring under long-standing provocation. Their conduct was one of righteous indignation rather than of the latent or inherent rowdiness which some of the journals have rather ungenerously imputed to them.

Patent Medicines in the Antipodes.

The Commonwealth Government of Australasia seem resolved to attack the evils of the patent medicine trade with stern determination. A short Bill has been announced, to be introduced as a supplementary measure to the Commerce Bill, in order to confer greater powers of control over the importation of those proprietary goods. The advent of this Bill is announced in the *Australasian Mail* of November 17th. It will enable the Minister of Customs—directly, and without any loophole for equivocation being given—to insist upon the labels of the bottles of all imported medicines bearing such indication as to the nature of the contents as the Minister may deem necessary. The necessity of supplementary legislation was forced upon Sir William Lyne, who had imagined that sufficient power was already conferred by the Commerce Act, but he had subsequently been informed by the Crown Law Officer that to remove all possibility of disputes a special Bill was necessary. By this step the stern rebuke is offered to the United Kingdom, whose worthless and dangerous wares are thereby excluded from Australasian shores. The irony of the situation, interpolated as it is amid an economical tariff strife, may be accepted as a solid contribution to those who protest against the patent medicine traffic in the United Kingdom. If the Colonies one and all reject these noxious imports from the Mother Country, they will inflict a deadly blow against a ruthless social monster.

Tradesmen's Wrappers.

The pitfalls to health are so manifold and various that our eyes must necessarily be shut to many of them. At the same time there are a certain number that can be dealt with summarily if once haled before the bar of public opinion. Among these minor dangers come the newspaper coverings often used by tradesmen to wrap up butter, cheese, bacon, fish and other articles of food. It is simply appalling to reflect on the myriads of microbes that must be adherent to the surface of an ordinary newspaper that has been in the hands of readers and in many strange places before being stored in the tradesman's shop. One marvels that such a practice should ever have been permitted by a long-suffering public to exist. It is tolerably certain that when once recognised the dawn of better things will quickly arise in the shape of clean, white, preferably sterilised wrappers around all articles from butterman, grocer, provision vendor, fishmonger and other dealers in articles of food. Indeed, the better class tradesman has already abandoned the filthy newspaper for the attractive white wrapper.

Sandow as Physician.

Let the cobbler stick to his last, and let the professional strong man attend to his own legitimate business. Mr. Eugene Sandow was the first to show what marvels could be accomplished by the systematic cultivation of the human muscles. No one can complain if he advocates his methods of physical culture as conducive to health, and even indirectly curative in various minor troubles, just as golf, or rowing, or riding, or other exercise is an aid to health. But when Sandow plays the physician and claims to cure a long list of maladies, including dyspepsia, nervous diseases, gout, rheumatism, paralysis, heart, chest, lung and "various other complaints," then we see no particular reason why he should not be classed with other quacks. Presumably in all or nearly all cases he makes his own diagnosis, a fact that at once vitiates hopelessly his statistics both of the nature of cases and of cures. How is a man to distinguish between a trivial and a most serious form of dyspepsia? In the latter event it may be, of course, merely symptomatic of such things as cancer, advanced disease of liver, heart disease, or consumption. If Sandow claims to cure "dyspepsia" with his exercises he is by inference asserting his ability to deal with any of the causes mentioned. This single instance suffices to show the self-sufficient and unblushing temerity with which the amateur and untrained physician is prepared to tackle any ill that human flesh is heir to.

Sarcoma and the Compensation Act.

The relation of malignant disease to industrial occupation is likely to give rise to a goodly number of keenly disputed cases under the new Workmen's Compensation Act. Already two cases in which sarcoma was alleged to have followed injury have been decided in favour of the workmen. In one instance the sarcoma affected the jaw, and was said to have been the result of an accident. In the second a leg was amputated for sarcoma in the lower end of the femur, said to have resulted from an injury some three months before the growth was recognised. Curiously enough the majority of the text books on surgery are silent as to the possible or probable relation of sarcomatous growths to traumatism. There are two notable exceptions, however, in Bland Sutton's book on "Tumours," and in Sir Frederick Treves's "System of Surgery," both of which accept the theory of traumatism as a cause, at any rate, in periosteal and by implication in endosteal forms of sarcoma. As other cases of the kind are certain to occur from time to time, it is highly desirable that surgeons should endeavour to formulate some fairly definite conclusions in this interesting point of etiology. From the circumstances of the case it is difficult to establish absolute data, but with further extended and concentrated observation it should not be impossible to arrive at an authoritative verdict as to the balance of probabilities in this alleged relationship.

Property in Dead Bodies.

Arising out of our note on "Property in Museum Specimens," in the issue of November 20th, in which we said that "it might be possible to prosecute a scientific enthusiast of such a kind [*i.e.*, one who stole museum specimens] for stealing the glass jar and spirits, and even for damage to the jars," a correspondent reminds us of a curious incident. In the days of body-snatching every "sack-em-up" was aware that his avocation, dangerous as it was, was not illegal if he merely captured the naked body, whereas removal of any of the grave-clothes was punishable. In the latter half of the eighteenth century, when Cornelius Magrath, the famous Irish giant died, Robinson, the Professor of Anatomy in Dublin, is reported to have said to his class:—"Gentlemen, I have been told that some of you in your zeal have contemplated carrying off the body. I must earnestly beg of you not to think of such a thing: but if you should be so carried away with your desire for knowledge that thus against my expressed wish you persist in doing so, I would have you to remember that *if you take only the body, there is no law whereby you can be touched, but if you take so much as a rag or a stocking with it, it is a hanging matter*" ("James Macartney," by Alex. Macalister. 1900. p. 16-17). Needless to say that in a few days the good professor himself dissected the body, and Magrath's skeleton still remains in the museum of Trinity College.

Indian Methods for Delirious Patients.

The sentence of death recently passed upon a Cree medicine man, in the Keewatin territory, reveals a curious practice in that remote tribe. The trial, which was noticed in the *Times* of October 28th last, originally extended also to an old chief, but the latter strangled himself while in custody. The charge was that of having put a delirious woman to death. One of the witnesses confessed that another murder of the same kind had taken place three weeks later, he himself helping to hold down the victim—a sick man who had been brought by his wife from another tribe simply to be put out of the way. The medicine man was condemned to death, but recommended to mercy on account of his ignorance. Immediately after the trial a party of mounted police set off on the 400-mile journey to Gurry Lake, in order to arrest several Indians concerned in another murder of the same kind, which is believed to have been the twenty-sixth committed within the last twenty years. The putting to death of delirious persons is probably due to a belief in their demoniacal possession. It is not so many generations ago that our own treatment of lunatics was almost equally primitive in practice. A plausible explanation of the matter is that the natives desire to get rid of helpless persons who consume their share of a limited supply of food, although themselves unproductive. In certain savage tribes, as in Patagonia, it is a recognised custom to destroy the aged and useless members of the community.

PERSONAL.

H.M. the King has sent his annual subscription of £100 to the Middlesex Hospital.

Mr. R. A. Bickersteth was elected Surgeon to the Liverpool Royal Infirmary on November 21st.

The Master of the Apothecaries' Society, Dr. George Wilks, took the chair at the Lord Mayor's Day dinner given by that company.

Dr. F. Henry was, on November 19th, at a meeting of the Liverpool Select Vestry, appointed Medical Superintendent of the Highfield Infirmary.

Sir R. Douglas Powell, President of the Royal College of Physicians of London, opened the Tuberculosis Exhibition in Belfast last Friday.

Dr. Sidney P. Phillips will take the chair at the annual dinner of the Harveian Society at the Imperial Restaurant to-morrow (Thursday) at 7.30 p.m.

Mr. Rockefeller has given £520,000 for the permanent endowment of the Institute for Medical Research which he founded at New York in 1901.

Sir Alfred H. Keogh will hold conferences with the medical profession at Exeter and Plymouth early next month on the proposed medical service for the Territorial Army.

Lady Theodora Guest has presented to the Westminster Hospital, at Shaftesbury, a fully equipped operating room as a memorial to her mother, the late Marchioness of Westminster.

Prince Ranjitsinji has given Rs.1,000 to the Jamsetjee Jeejeebhog Hospital at Bombay as a token of the skill and devotion shown him during his late illness by a nurse from that institution.

Sir William Bennett, K.C.V.O., Consulting Surgeon to St. George's Hospital, has been elected President of the Incorporated Institute of Hygiene in place of the late Sir William Broadbent, Bart.

The Faculty of Medicine of London University have appointed Professor Ernest Henry Starling, M.D., B.S., F.R.C.P., F.R.S., to be their representative on Senate for the remainder of the period 1905-9, vice Dr. Lauriston E. Shaw resigned.

Dr. G. E. Cartwright Wood, Bacteriologist to the Laboratories of the Royal College of Physicians and Surgeons, London, has been appointed by the Metropolitan Asylums Board as Bacteriologist at their establishment at Belmont, at a salary of £600 a year.

A CLINICAL LECTURE

ON

LINGERING LABOUR; ITS CAUSES AND TREATMENT. (a)

By JAMES MORRISON, M.D.Lond.,

Hon. Physician Accoucheur Farringdon Dispensary and Lying-in Institution.

GENTLEMEN,—First of all, I want to show you this Barnes-Galabin-Simpson variety of forceps, the only forceps on the market which allows the manipulations of two pairs of forceps in a single instrument.

In regard to our subject for this afternoon, lingering labour, I would like to remind you of some of the points, because I am constantly being called in to cases of lingering labour in which there should be no difficulty. By "lingering labour" I mean labour where there is no mechanical obstruction to the birth, both passages and passenger being normal, and the cause of such labour is some fault in the forces. In the primipara the full time which should be taken for the whole confinement is 24 hours, and in the multipara 12 hours. That, of course, is a very long time, particularly in general practice, and therefore the second stage in the multipara is often cut down to nil. You may say that for the primipara the first stage is 16 hours, and the second 8 hours; and in the multipara 8 hours and 4 hours respectively. But you can never do wrong by waiting in the case of the primipara. In multipara you can cut it down to 4 hours justifiably by putting on forceps. It is an unwritten rule at Queen Charlotte's to cut short the second stage in a multipara after two hours by putting on forceps—that is to say, lingering labour, where there is no obstruction, but where the pains are wanting or are insufficient, and so the labour is delayed over the average time.

The causes of delay in lingering labour may be classified as those due to the mother's general condition, causes in the uterus, and causes in the passages; there are also causes on the part of the child. If the child is too large, the labour will be an obstructed one. All sorts of debilitating diseases will lessen the mother's expulsive force; anæmia, lung troubles, and the wasting due to starvation are the common ones. I do not propose to go into these to-day. You must always be on the look-out for diverticula and pendulous belly. If you stand the patient up, you may find that, instead of the child pointing downwards and backwards towards the coccyx, the abdominal walls are pendulous, and the child more or less looks upwards and backwards. The absence of pains is due to what is called primary uterine inertia. The tonic contractions belong to obstructed labour, not to lingering labour. Primary inertia means that the pains are weak from the beginning; the woman has never had pains strong enough to expel the child. That very seldom occurs in the primipara, but in the multipara it is common. In pendulous belly there is a lack of abdominal pressure owing to weakness of the recti. Secondary uterine inertia means that the pains have been strong, but that they have then got weaker and gone off. The commonest causes of these are, 1st, that the woman has not been properly taught how to bear down; 2nd, she is not well under the doctor's control; she is tossing about, and refuses to do anything she is told, and when the pains come on she screams. She does not make use of the pains, the child does not advance, and after a time she naturally becomes exhausted; then the pains get weaker, and pass off. When this happens, many men, having watched the case for several hours, bring up their forceps and put them on. That is quite the wrong thing to do, for the result is post-partum hæmorrhage. They do not know what to do, so they put on a binder, and hope for the best. Many years ago, when I was a "locum," I had three or four of these cases in one week. The practitioner had come back to the surgery, and shortly afterwards received a message that the woman was bleeding. He said he was too busy to go—would I mind? Some of them were nearly moribund, and in each case he had put on forceps because he could not wait. The uterus is clogged, and you cannot get any stimulation of it; so after the child is delivered you perhaps use a hot uterine douche, but it will not contract. The reason is that the nervous arc is broken at the nerve end-plates, which are clogged up with the products of the constant contractions. You can give smelling-salts, put the child to the breast, apply cold water to the abdomen, and give a uterine douche, but the placental site will bleed because of this clogging with the products of nervous waste due to the continual strong pains. In those cases there is nothing to do but plug the uterus.

In regard to the ovum itself, one very common cause of lingering labour is premature rupture of the membranes; perhaps it is the cause in nine cases out of ten. In the posterior cases the lower uterine segment is not properly filled by the head, the woman bears down before the cervix is opened, and there is, therefore, premature rupture of the membranes. And later on, the head not being properly flexed, the occiput remains behind, and you have to put on forceps. I want to devote a good deal of attention to-day to the subject of the premature rupture of membranes. The membranes may be too adherent round the internal os, which you notice more in placenta prævia. Then there is over-distention of the uterus, so that the uterus cannot get a "purchase" on the child. Other causes are hydramnios and twins. In that the delay is in the first stage; everything goes right after the membranes are ruptured. It is common for the first stage to be delayed 24 or 36 hours, and I have seen cases in which the pains have continued for three days, but were not strong enough to open up the cervix.

Let us consider the commonest cause of lingering labour—the premature rupture of membranes. The treatment depends on the stage at which you meet with it. If the membranes are ruptured with the cervix half an inch or so thick, the treatment differs from that where the cervix is open and the walls thin. If you get the case early, and the cervix is still thick, and is not fully dilated, do not put on the forceps. Never put on forceps with an undilated cervix. Use de Reeve's (?) bag. Absolutely the best use of this bag is in premature rupture of membranes. Before the cervix is open, the uterus turns the dilating force into an expulsive force, and the uterus pushes the child on to the cervix, the cervix gets emptied and closes up again, and there is a hard, rigid, contracted cervix, with spasm. To prevent that, put in this bag and replace the membranes. In that way you save hours, because the labour now goes on in the normal way. You can alter the tension of the bag by pulling on the tube, and when the bag comes out, the os will be sufficiently dilated for the bag to pass. If you have not this bag, use an ordinary penny air-ball blown out and tied on to a catheter, and an ordinary pair of forceps will be sufficient for introducing the bag. This bag can be introduced into a cervix which admits two fingers; afterwards loosen your forceps and turn on the tap. Blow it up with water, and as it fills see that this is well inside the cervix, and afterwards extend it up as far as it will go. Then take out the forceps, which can be removed separately. If you have a difficulty in getting the bag inside, fix the anterior lip with a volsella. With the Barnes bag it is necessary to have a number of them, and therefore the risk of sepsis is increased. You only want one such bag as I show you; it is easily sterilised. Sometimes these cases of premature rupture come off without trouble, but the majority of them cause delay; therefore do not wait until you replace the bag of membranes. If you cannot introduce the bag because the cervix will not admit two fingers, you must wait, and, while waiting, give chloral, a 1-drachm dose by the bowel. It is supposed to have a specific action on the cervix, and I think it has. I have given drachm doses hundreds of times, and I have never had a bad result from it, though some people say chloral is not a safe drug to use. You can repeat in ½-drachm doses. If you have a case in which you have not put on your de Reeve's bag, and you are sorry for it, and where labour has been going on longer, and the uterus has emptied itself of its liquor amnii, the cervix is still in front of the head, and very often the anterior lip is nipped between the child's head and the pubes, and therefore gets œdematous; the pains are very great, causing the woman to shriek; those cases want treatment quite differently. You find a thin os, and the child's head will descend before the osseous canal is open. It is of no use putting in a bag, because if you begin to push up the child you will risk rupturing the uterus. You give the woman chloroform, and it acts like a charm—perhaps in ten minutes the whole case is over. The head is rammed down on the cervix, and causes it to be irritated and go into spasm, and that causes the painful contraction. By giving chloroform you relieve the pressure, and take the head off the cervix, and the cervix opens up. You can either put on forceps or let it deliver naturally, but the case is over. Chloroform acts better and quicker in these cases than opium.

(a) Delivered at the Medical Graduates' College and Polyclinic, Chenies Street, W.C., on Monday, July 8th, 1907.

NOTE.—The Author's corrected proof had not been received at the time of going to Press.—EDITOR.

There is a similar condition, but not so marked, where the pains are not so great and the descent is greater. The cervix is not so thin, and the os more open, but the swollen anterior lip protrudes from the vulva. There is a plum-shaped mass. Do not cut it off as a polypus. The treatment for that is, while the pains are off, put your finger between the head and the anterior lip, and try to stretch the cervix over the child's head. Between the pains there will be a distinct relaxation of the uterus, and the woman will allow you to press the anterior lip up.

Primary uterine inertia due to other causes must be treated in the ordinary way. Several things are often overlooked at confinements. The woman does not have rest and food. In primiparæ, very often two or three days before labour commences she has not been eating or sleeping. These two important points must be looked to. If the pains are not strong, give her plenty of liquid nourishing food and sedatives, opium being the best. When she awakes the pains will be stronger, and the birth will probably take place. The bowels and the bladder must be seen to. A loaded rectum was a common cause of lingering labour, but nowadays the bowels are better looked to. Still, a loaded bladder is a common cause, and later on it causes hæmorrhage. The doctor is continually in the room, and the woman has had her pains to think about, and even if she has thought about her bladder, she has not liked to say she wanted to empty it. If after that there is nothing in the way, the os is opened, and the labour is not coming off, the question is—when are you to interfere by putting on forceps? In a multipara, where there is nothing wrong with the passage or with the passenger, you are justified in putting on the forceps after two hours. You do so, not to pull the child out, but to help the pains. So you must pull with the pains, and relax between them. If the head is sticking in the upper part of the pelvis, put on axis-traction forceps. If the child is sticking in the lower part, put on the ordinary ones. I advise you, for general practice, in these high cases, to put on axis-traction bars. With the ordinary forceps you are not pulling far enough back, and that makes all the difference as to whether the child comes down easily or not. Never put forceps on a primipara, however many hours you may have to wait. If you can get a woman through her first confinement without a temperature and without cutting, she will get through it without being a chronic invalid. If the ordinary married woman has instruments at her first confinement, she always seems to have something wrong with her afterwards. There is only one justifiable exception to this, and that is when the head sticks at the bony outlet, at the narrowest part of the pelvis. If the head does not advance, you are justified in putting on forceps. You pull the child's head a little bit past with one good tug, and immediately take off your forceps; don't attempt to bring the head over the perinæum. In the primipara you wait half an hour before putting on the forceps to see if the head advances. When the head is once through the bony outlet, it will never slip back. Bathe the perinæum with hot fomentations. Some doctors say they do not believe in fomenting the perinæum, but others do. Many of those who do not believe in it have applied a little warm water by means of cotton wool once every half-hour. That, of course, has no effect. You want a big diaper or plug of cotton wool, the water as hot as she can stand it, and soak the perinæum and right back on to the buttocks. If you look where the lines of stretching took place after the child is born, you find them on the buttocks and thighs, showing that those parts ought to be softened. In carrying out your softening, do it for half an hour, then give it ten minutes rest, and then go on for another half-hour. Let the head come forward and go back as often as you like, but each time it will come a little further. Whenever you get that backward and forward process on the perinæum, labour never stops, secondary uterine inertia does not come on at that stage, and the more often it does that the safer it is for the perinæum.

With regard to unfavourable positions, of course the great bugbear is the posterior case. You do not diagnose the posterior position until the membranes have been ruptured, and perhaps the head has descended well into the pelvis. But if you diagnose the posterior position only, before the rupture of the membranes, or while the head is still at the brim, or the cervix not fully dilated, it is justifiable to attempt to rotate the posterior cases into anterior cases. And I advise you to always give chloroform, and always introduce the whole hand into the vagina, seize the occiput, and pull it round to the front. You are working above the brim, and therefore you can do it. When you have got the occiput in front, keep it there. With the other hand rotate the anterior shoulder to the opposite side of the abdomen. If you do not do that it will get into the same position again. When the head is engaged in the pelvis, it will not move again, but if you have not got the shoulders round, the child will swing back again. The posterior fontanelle should be much lower than the anterior. As soon as you recognise that you have a posterior case, therefore, you push up the forehead and carry out what I have described.

Ordinary Unreduced Occiptio-Posterior Cases:—The treatment for this condition is either to put on forceps and pull the head down the perinæum, with the occiput behind, and then take off the forceps and allow the occiput to rotate to the front, and again put on the forceps in order to extract the head, or else put on the forceps the wrong way up, and as you pull down allow the forceps to rotate right round; in other words, anticipate the rotation of the occiput to the front. In putting on the forceps, introduce the left blade with the left hand, and with the edge of your finger on the blade rotate it round. Do not do this by the handle alone; you guard the blade from injuring the uterus by means of the hand. Do similarly with the right blade. I remember particularly a case in which an attempt had been made for several hours to deliver, and finally the instruments were laid out in readiness to do craniotomy. But they had not tried what I am now describing. I put the blade on in the way I have mentioned, and, with moderate pulling, I got the head down. It was a 12 lb. baby. I can assure you it is an extremely good tip for those cases.

The only other point about lingering labour is breech labour. In this kind there is nearly always a lingering labour, because you have the child coming the wrong way—that is, with the head and shoulders up above. Most of the force of the uterus is exerted in squeezing, like squeezing a pip between the fingers, but with the larger part above; the result of the squeezing is to force the child upwards instead of downwards. In a breech case leave the membranes intact as long as possible; do not rupture them, even if they appear at the vulva, because even when the breech has passed through the cervix the cervix is not dilated enough to allow the head to pass. Secondly, remember you have to deliver the child artificially, so you must be prepared to deliver. And you ought to have a systematic way of delivering the breech. When the breech comes down to the umbilicus, you must yourself start to deliver, because when the child has reached that spot it has only four minutes to live, because the placenta is beginning to be detached, and the child has half left the uterus. First look for the arms, and always be prepared to pull down the extended arms, the posterior arm first; then turn the child right round until the anterior arm becomes the posterior. Next deliver the head, and do not attempt to pull the head out until you have passed your hand in. Then put your fingers into the mouth. The head must come down transversely from the pelvis; pull it down from the brim to the floor. Don't attempt to rotate the child until the head is on the floor. You must not turn the back to the front immediately the shoulders are born, though that is the usual thing one sees. All the time you are delivering the breech you should either be pushing on the uterus or getting someone else to push down, because the more you pull from below the more you tend to extend the legs and arms. Deliver the breech always with the woman lying in the dorsal position across the bed. Secondly, always give chloroform if you possibly can, because it is painful to pass the hand in alongside the child's body. Of course, if more than four minutes have elapsed after the child has reached the umbilicus, and before it is born, you do not cease your efforts, but try to resuscitate the child. I have seen a child pulled round when it has been 20 minutes afterwards.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by R. W. Philip, M.A., M.D., F.R.C.P., F.R.C.S.E., Physician and Lecturer on Clinical Medicine, Royal Infirmary, Edinburgh. Subject: "Exophthalmic Goitre and Myxœdema."*

ORIGINAL PAPERS.

TUBERCULOSIS IN CHILDHOOD AND ITS RELATION TO MILK. (a)

By JOHN M'CAW, M.D., R.U.I., Etc.,

Senior Physician to the Belfast Hospital for Sick Children.

DURING the past few years, and especially at the present time, the tuberculosis question has engaged and is engaging the attention of the medical profession in all countries. A campaign is being carried on against tuberculosis which has already resulted in much benefit, and bids fair to eventually stamp out the disease completely. Whether or not this highly desirable result will be attained in our time is very doubtful, but it is satisfactory to know that the means by which the disease is generated and spread are well known, and that prevention is not impossible.

The medical profession in Ireland have not been behind-hand in this campaign. The large amount of tuberculosis existing in Belfast has been very forcibly brought out by means of letters in the local Press, and especially by statistics submitted by the various witnesses who appeared before the Health Commission. Further, the Registrar-General of Ireland, in his annual report for the year 1906, points out that out of a total of 74,417 deaths registered no fewer than 11,756, or 15.8 per cent., were due to tuberculous disease. Of the total number of 11,756 deaths, the number dying from phthisis (pulmonary tuberculosis) was 8,933. Of this total, 1,072 died between the age of 15 to 20 years; the deaths from 20 to 25 years numbered 1,444, and from 35 to 45 years they numbered 1,557. The report of the Superintendent Medical Officer of Health of Belfast shows that during the year 1906 1,015 deaths were registered in Belfast as caused by phthisis, and 395 from other forms of tuberculous disease.

Finally, the Registrar-General for Ireland points out that, while in England the death-rate for all forms of tuberculous disease has declined from 3.3 per 1,000 in 1864 to 1.6 per 1,000 in 1905, and in Scotland from 3.6 per 1,000 in 1864 to 2.1 per 1,000 in 1905, it has in Ireland risen from 2.4 per 1,000 in 1864 to 2.9 in 1904 and to 2.7 per 1,000 in 1905 and 1906. With these figures before me I think I am justified in saying that in no country is it more desirable to pursue a vigorous campaign against tuberculosis than in Ireland, and in no city in the United Kingdom is a better opportunity afforded for studying and fighting the disease than in Belfast. Our position, therefore, with regard to the large amount of adult tuberculosis existing in Belfast, is well known and assured, and to it I need not further refer; but what about tuberculosis in childhoood? As a separate enquiry this aspect of the question has been but lightly touched upon, and I shall endeavour, as far as possible in the time at my disposal, to supply the omission in what follows.

My connection with the Belfast Hospital for Sick Children for the past twenty years has given me exceptional opportunities for studying the disease, and I shall now place before you, as shortly as possible, the main points with regard to tuberculosis in childhood, and lay special emphasis upon the connection which exists between tuberculosis and cows' milk. In order that my remarks may be quite clear and readily followed, I shall discuss the subject under the following heads:—(1.) What amount of tuberculosis in children exists in Belfast? (2.) What types of the disease are met with? (3.) What connection exists between tuberculosis and cows' milk? (4.) What can be done to prevent or cure the disease?

1. WHAT AMOUNT OF TUBERCULOSIS IN CHILDREN EXISTS IN BELFAST?—In conversation with the physicians and surgeons attached to children's hospitals I find a general consensus of opinion that tuberculous disease of one kind or another forms a very considerable part of their work in these institutions, and Professor Holt states that autopsies on children dying from all causes under 15 years of age, show the presence of tuberculosis estimated by various observers at from 14 to 40 per cent. I think the statement may safely be made that a large amount of tuberculosis exists among children. That this opinion is well founded, I shall now endeavour to support by a few statistics. At the Children's Hospital, in Queen Street, during the quinquennial period 1902-06, 26,193 cases were treated, and tuberculous disease in some form was met with in almost 20.0 per cent.—to be accurate, in 19.99 per cent. of them. Of this total, 4,049 were treated as in-patients in the wards, and 28.52 per cent. of them were tuberculous, while 22,144 new cases were treated in the out-patient department, and 18.26 per cent. suffered from tuberculosis in some form.

The interesting question arises: How do we in Belfast compare with other cities in regard to the amount of tuberculosis met with in children? To arrive at an answer to this question I have examined, on exactly the same basis, the returns of the cases treated at various hospitals, as follows:—

(a) An address delivered at the Opening Meeting of the Ulster Medical Society.

Belfast Hospital for Sick Children	—**No. of intern patients, 828; No. tuberculous, 28·74 per cent.**
Ulster do. do. do.	—**No. of intern patients, 247; No. tuberculous, 30·36 per cent.**
Great Ormond Street, London...	—**No. of intern patients, 2,876; No. tuberculous, 27 per cent.**
Royal Edinburgh Hospital ...	—**No. of intern patients, 1,968; No. tucerculous, 20 per cent.**
Manchester Children's Hospital	—**No. of intern patients, 1 999; No. tuberculous, 21·3 per cent.**
East London do. do.	—**No. of intern patients, 2,054; No. tuberculous, 24·3 per cent.**
Glasgow do. do.	—**No. of intern patients, 1,177; No. tuberculous, 27·95 per cent.**

This table shows a wonderful agreement amongst the returns of these hospitals as to the amount of tuberculosis met with. My firm conviction is that all children's hospitals meet with much the same amount of tuberculosis, and that that amount is very large.

2. What Types of the Disease are Met With?—A glance at the statistics which I have given will be sufficient to demonstrate the fact that a certain number of the cases of tuberculosis met with at the children's hospitals are deemed suitable for treatment in the medical wards, while others are more properly sent to the surgical side. From this, then, one might say that there is a medical as distinguished from a surgical form of tuberculosis; and while this is true enough, still it is not sufficient, nor does it satisfy the question.

One of the most noteworthy deductions from the statistics is the preponderating amount of surgical tuberculosis met with when compared with that seen by the physician, and this point I wish very specially to emphasise, as having a most important bearing on causation and treatment. If the returns of the hospitals mentioned be examined, it will be found that the cases treated on the medical side consist of phthisis and meningitis, spinal caries and general tuberculosis; while on the surgical side the surgeon is deluged with chronic abscesses, tuberculous joints, lymphadenitis, and chronic ulcers. But it should be noted that many of the cases treated in the medical wards would be more properly classified as surgical—such, for instance, as lupus, spinal caries, etc.—which, if added to the surgical figures, would still more emphasise the preponderance of surgical over medical tuberculosis. These facts suggest the question, is the disease as seen by the physician only another form of that met with by the surgeon, or are they different types of the same disease, and caused by a bacillus of a different species?

Recently the theory has been put forward that tuberculous affections of the human body are divisible into two types:—(*a*) a type caused by tubercle bacilli from the human, and called the "typus humanus"; and (*b*) a type caused by tubercle bacilli from the cow, and called the "typus bovinus." These bacilli are varieties of the same species, but they give rise to quite distinct and different lesions, according to the method of infection. In the first (or human) type, the bacilli are inhaled in dust, and find a lodgment in the apex of the lung. From this site of infection the disease may spread and cause secondary infection of the intestines, or set up a tuberculous laryngitis. In the second (or bovine) type, the disease is conveyed indirectly by means of tubercle bacilli taken into the body in raw milk, meat, etc. Here the infection is carried to the intestines and mesenteric glands, and gives rise to tabes mesenterica, tuberculous peritonitis, tubercle of the pelvic organs, tuberculous lymphatic glands, tuberculous bones and joints, lupus, tuberculous meningitis, or acute miliary tuberculosis. Much may be said in support of this theory; and I will content myself at present by pointing to the enormous amount of surgical tuberculosis met with at an age when cow's milk is largely availed of—indeed, is the chief article of diet—as a circumstance of the highest moment, and also to the following extracts from the report of the Royal Commission on Human and Bovine Tuberculosis. In that report (page 10) the effects of feeding calves with the bacillus of bovine tuberculosis are set forth as follows:—In each of six cows, whose udders had been made tuberculous by intra-mammary injection, the calves were allowed to suck for varying periods. In one case only was general tuberculosis produced. In all the other five calves killed, after being kept alive from 74 to 363 days, the tuberculosis was for the most part limited to the intestines and mesenteric glands. Fourteen calves were fed with tuberculous milk, the number of bacilli ingested varying from one to ten millions. None of these calves showed when killed anything more than tuberculosis limited to the intestine and to the mesenteric or ileo-colic glands; in one case tuberculous lesions were found in the pharyngeal glands. In other animals the results are no less striking. Thus a quantity of milk from a tuberculous udder produced in each of two pigs tuberculous disease of the mesenteric and ileo-colic glands. In goats, feeding sometimes produced a generalised progressive tuberculosis; at other times the disease was limited for the most part to the mesenteric and adjoining glands. In anthropoid apes, a chimpanzee was fed for a week with tuberculous milk, the number of bacilli given being estimated roughly to be 100 millions. It was killed when very ill, 100 days later, and showed generalised progressive tuberculosis; the intestines and associated glands were tuberculous, and there were also tubercles in the lungs, thoracic glands, spleen and kidneys. Another chimpanzee received 10 million bacilli, tuberculous milk being the medium. It died 144 days afterwards, with tuberculous ulceration of the intestines, and caseous or caseo-calcareous lesions in the mesenteric and mesocolic glands. The tuberculosis was, therefore, limited. These experiments, then, in the anthropoid ape, an animal so nearly related to man, are of the highest importance, and point clearly to the fact that when the dose of bovine tubercle bacilli taken into the system is large, a generalised tuberculosis, starting from the intestines and mesenteric glands, is set up; whereas when the dose is moderate, the affection may remain confined to the intestines and mesenteric glands, which in time may extend to other glands and bones and joints. Here, then, I submit is evidence sufficient to support the contention that the large percentage of tuberculosis met with in children is bovine, and caused by the ingestion of bovine tubercle bacilli in milk, meat, etc., and that this form of tuberculosis is chiefly surgical. But this theory goes a step further. It is affirmed by some that these two types of the disease are more or less antagonistic, so that a child when it becomes affected with bovine tuberculosis absorbs an antitoxin, which protects it against the human type of the disease, and similarly the human type renders it either less liable to be attacked by, or immune against, the bovine bacillus. In support of this contention the rarity of pulmonary tuberculosis in association with tuberculous glands, or joints, or bone disease is pointed to; and the further fact is relied upon, namely, that the vast amount of tuberculosis met with in the child is surgical, the result of infection with bovine bacilli, and also that the adult or human type of the disease is quite rarely met with at an early age.

To carry this argument to a logical conclusion: if this theory be correct, then human serum, or tuberculin R., should be beneficial when used for surgical or bovine tuberculosis; and, *vice versa*, bovine serum should be beneficial in tuberculosis of human type. Much evidence could be adduced in support of this contention, and my experience, but more especially the experience of surgeons, is, that in limited tuberculous lesions of a surgical nature the injection of tuberculin R. is followed by favourable results. Dr. Nathan Raw, of Liverpool, whose work in this connection has been very extensive, writes me to say that he has obtained the most gratifying results from the use of these serums, and, after long observation of clinical cases, and extensive laboratory work, he is convinced the theory is sound. I cannot, however, now wait to discuss this point further, but I should like to make the suggestion that during the session an evening might be very profitably devoted to a discussion of this subject. The third question to be answered is:—

3. What Connection Exists Between Tuberculosis in Children and Cows' Milk?—As I consider this to be a very important part of my subject, I should like to emphasise its importance as much as possible, for two reasons—*first*, because the connection is a very close and vital one, as I shall endeavour to prove; and, *secondly*, because no serious attempt has yet been made by the authorities to determine the amount of tuberculosis existing among dairy cattle, much less to adopt such measures as are necessary to stamp out bovine tuberculosis. In what has gone before, I have shown that a large amount of tuberculous disease exists amongst children. Let me now draw your attention to the fact that the disease appears at a time of life when cows' milk is the main, or almost the main, article of diet. These two statements taken together are sufficient to establish a *prima facie* case against cows' milk. Further, I have shown that tuberculosis in children is very largely of the surgical type—that is, it is chiefly glandular, and almost certainly due to the bacillus of bovine tuberculosis which has been taken into the system in food. In support of this the following definite pronouncement of the Royal Commission is of the highest moment. On page 36, paragraph 66, of their report is the following:—"There can be no doubt but that in a certain number of cases the tuberculosis occurring in the human subject, *especially in children*, is the direct result of the introduction into the human body of the bacillus of bovine tuberculosis; and there can also be no doubt that in the majority at least of these cases the bacillus is introduced through cows' milk. Cows' milk containing bovine tubercle bacilli is clearly a cause of tuberculosis, and of fatal tuberculosis, in man. Of the 60 cases of human tuberculosis investigated by us, 14 of the viruses contained the bovine bacillus. If, instead of taking all these 60 cases, we confine ourselves to cases of tuberculosis in which the bacilli were apparently introduced into the body by way of the alimentary canal, the proportion of cases of bovine infection becomes very much larger. Of the 60 cases investigated by us, 28 possessed clinical histories indicating that in them the bacillus was introduced through the alimentary canal. Of these, 13 contained the bovine bacillus. Of 9 cases in which the cervical glands were studied by us, 3, and of the 19 cases in which the lesions of abdominal tuberculosis were studied by us, 10, contained the bovine bacillus. These facts indicate that *a very large proportion of tuberculosis* contracted by ingestion is due to tubercle bacilli of bovine source. A very considerable amount of disease and loss of life, *especially among the young*, must be attributed to the consumption of cows' milk containing tubercle bacilli, . . . for the bacillus of bovine tuberculosis can readily, by feeding as well as by subcutaneous injection, give rise to generalised tuberculosis in the anthropoid ape, so nearly related to man, and, indeed, seems to produce this result more readily than in the bovine body itself." After these weighty words it is quite unnecessary for me to labour the point further, and, indeed, it would be a waste of your time were I to do so. This pronouncement of the Royal Commission establishes a close and clear connection between cows' milk and tuberculosis in children, and must be considered final.

4. Finally, What Can be Done to Prevent or Cure the Disease?—With regard to the first part of the question—how can we prevent tuberculosis in childhood? I think I may safely say a general opinion exists that our best hopes for eradicating the disease lie in the direction of preventing it, and accordingly measures adopted for prevention must be energetically pursued. Two eminent opinions have been expressed on this point from which we may obtain guidance, namely, that of Professor Koch, who lays stress upon the transmission of the disease by contagion, especially by means of the respiratory organs; and that of Professor Von Behring, who is of opinion that tuberculosis in children is principally disseminated through the alimentary canal, and he sees a fruitful source of danger to children in the tuberculous nature of much of our milk supply. I think both these pronouncements are true, but I hold strongly that the latter theory is the more important one as regards children. Acting upon Koch's opinion it is necessary that children be kept apart from those suffering from pulmonary tuberculosis, whose breath and sputa are loaded with infectious germs. This has been recognised in Germany, where visits are made to the houses of consumptives, children are removed, when this is possible, from such surroundings, directions are given and patients are taught the most efficient means of disinfecting and disposing of their sputa, and the necessity for keeping their clothes, beds, furniture, and floors clean. Such means as these constitute a powerful factor in limiting the area of the disease and diminishing its virulence. Then much good has resulted from convalescent homes in the country, holiday camps, and forest schools. The country homes are simple but suitable buildings put up somewhere in the woods to which children may be taken and kept for the entire day. At these homes everything is conducted upon strictly hygienic lines, from the proper cleansing of the children to the furnishing of a suitable dietary, and the enforcement of physical exercise.

Coming now to Von Behring's view that tuberculosis in children is principally disseminated through the alimentary canal, I believe we have here the most important factor in the tuberculosis of children. Many eminent authorities in this country adhere to this view, and have given expression to the opinion that the bacilli found in these cases are most commonly of the bovine type, and gain entrance into the system by means of the milk of infected cows. It may here be asked, what amount of bovine tuberculosis exists? The report of the Royal Commission on Tuberculosis states that "of all animals slaughtered for food in Great Britain and Ireland those of the bovine race seem to be more largely affected with tuberculosis than any other." In the absence of statistical information as regards our own country, the report proceeds to show that, in Leipzig, of 9,303 cows slaughtered, 4,048, or 43.51 per cent., were tuberculous. The proportion of such diseased cattle in English cow-houses, which has been publicly and authoritatively stated to be about 30 per cent. by the late Professor MacFadyean, is, therefore, probably not excessive. In the year 1901 there were 1,887,414 milch cows in England, and 4,102,061 in the United Kingdom. Thirty per cent. of these means upwards of 560,000 tuberculous cows for England alone, and nearly 1¼ millions for the United Kingdom. If 5 quarts of milk be allowed as a fair average yield per day for each cow, then 6,250,000 quarts of milk, the daily yield of tuberculous cows, are consumed each year in the United Kingdom. Again, it has been calculated, and is admitted, that tuberculosis of the udder exists in 2 per cent. of dairy cows in the United Kingdom; this means that some 20,000 cows with active tuberculosis of the udder are to-day contributing to our milk supply, and some 100,000 quarts of milk teeming with virulent bovine tubercle bacilli are consumed each day in the United Kingdom.

When it is remembered that even one diseased udder is capable of disseminating a huge number of tubercle bacilli, the bare idea of the amount of possible human tuberculosis from the milk of so immense a number of diseased cows is appalling. I regret I am unable to place before you any statistics bearing upon the prevalence of tuberculosis in cattle supplying milk to Belfast, but the following figures, taken from the report of the Medical Officer of Health of Manchester, Dr. Nevin, are interesting in this connection:—During the year 1904, 432 samples of milk were examined, the number of farmers represented in the total being 318. Of these 318 farmers, 188 reside in Cheshire, and 21 of them (or 11.17 per cent.) sent tuberculous milk; 83 live in Derbyshire, and 5 of them (6.02 per cent.) sent tuberculous milk; 14 reside in Lancashire, and 1 of them (7.14 per cent.) sent tuberculous milk; 8 reside in Yorkshire, and 2 of them (25.00 per cent.) sent tuberculous milk. Are we in Belfast any better off in regard to the number of diseased cows supplying milk than Manchester? My firm belief is we are not. I am confirmed in this opinion from what I have seen when visiting some of the dairies within the city, and that much tuberculous milk is purveyed in our midst I think admits of no doubt. It is clear, therefore, that a large amount of tuberculosis in cattle exists, and the connection between the disease in cattle and tuberculosis in childhood having been established, it follows, if we would prevent the disease in children, the first and most important step is to stamp it out in cattle. In considering how this may be done it is necessary to remember that in tuberculosis, before the formation of tubercles in any part of the body, there is a stage of the disease of unknown duration during which the bacilli multiply and circulate throughout the body. To regard the disease as beginning with and being localised in tubercular formations is to fail to recognise the bacillary stage of the disease, and is therefore wrong. This pre-tubercular stage can only be detected by means of the tuberculin test; therefore, it becomes imperative that this test be applied to all dairy cattle, and that every cow reacting to this test be withdrawn and the carcass destroyed. To ensure success, however, compulsory and universal application of the principle is necessary. Fair compensation for the loss to the stock-owner should be granted; and, probably, the sum of money that would be required for this purpose is the main objection to the enforcement of the measure by the Government. In the year 1865-66 an outbreak of cattle-plague occurred in this country, which involved the death of 233,000 head of stock. And what took place? The first consideration was the stamping-out of the disease as quickly as possible, and at any cost. But tuberculosis in animals is more widespread than cattle-plague has ever been: it is always present in our herds, whereas outbreaks of plague are few and far between; and, what is worst of all, tuberculosis causes a vast amount of sickness and suffering and death and despair, which cattle-plague does not do. Surely this most astounding condition of things will not be permitted to continue much longer. The public—and, more especially, we members of the medical profession—should now and at once insist, both on hygienic and economic grounds, that it is urgently necessary to stamp out this awful disease of tuberculosis in cattle. It is estimated that the disease in animals may be eliminated in a single year, and, if so, what a year of triumph that would be!

To protect children from the ravages of tuberculosis, the following rules may be formulated:—

1. The Notification of all Births Within Twenty-Four Hours.—This would enable health visitors to examine into the state of the child's surroundings; to have the child removed, or precautions taken, should any case of tuberculosis exist in the house; and to give suitable directions for the care of the child, and especially to encourage breast-feeding.

2. Complete Control of the Milk Supply by the State.—This should include the application of the *tuberculin test to dairy cattle*, and the removal of all such as react to this test; cleanliness in the collection of all milk, and in the transmission of it from the dairy to the consumer; the removal of dairies from the centre of large town and cities.

3. Medical Inspection of School Children and School Premises.—First, to detect and remove children who are actually ill or unfit to attend school; and, secondly, to ensure proper ventilation and sanitary arrangements in the schools, and to prevent overcrowding. The elementary principles of hygiene should be taught to even young children; to older children the principles of domestic hygiene and economy should be added.

4. Dwelling-houses in the poorer districts should be made more sanitary, especially with regard to the free access to them of sunlight and fresh air. Ireland is behindhand in this respect—a circumstance which may, in part, account for its high death-rate from phthisis. A levelling-up of the social and domestic conditions of the poor is urgently required; for of the 1,200,000 children born each year in the United Kingdom, fully one-fourth to one-third of them are born to want and squalor.

5. All advanced cases of phthisis should be segregated as far as practicable and treated in special institutions set apart for that purpose. Children who are allowed to live in the house with a consumptive are exposed to serious risk.

6. Notification of the disease should be compulsory. By this means health officers would know where the disease existed, and it would enable them to take suitable precautions against the spread of the disease by disinfection and other means.

With the second part of the question—*What can be done to cure the disease?*—I need not detain you long. I have said that the large proportion of tuberculosis in childhood comes within the purview of the surgeons, and with them the treatment may safely be left; for Belfast is fortunate in having a band of gentlemen second to none in the kingdom for operative skill and surgical acumen.

With regard to the use of tuberculin, the scientific investigations concerning it have placed in our hands a remedy of the greatest value. Unfortunately, the profession still feel a want of confidence in it, or a dread of its reaction, but it should be remembered that the use of tuberculin at the present time is very different from what it was when first introduced. Formerly tuberculin was administered by rule of thumb, and often with disastrous results; now, thanks to the brilliant researches of Sir A. E. Wright, and the discovery by him of the opsonic index, the dose of tuberculin, its effects, and the most suitable times for injection, can be regulated with scientific precision.

This discovery has in fact brought treatment with tuberculin within the realm of safe therapeutics, and the clinical success which has attended the employment of this treatment has firmly established its position as a remedial agent of the first importance. In addition to the use of tuberculin, our efforts to cure tuberculosis, or stay its progress, must include good and wholesome food, healthy hygienic surroundings, an abundance of pure air, and such drugs as cod liver oil in combination with the hypophosphites.

THE ABORTIVE TREATMENT OF SYPHILIS BY THE INTENSIVE METHOD.

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[Specially Reported for this Journal.]

The possibility of definitively cutting short an attack of syphilis by early intensive treatment has not so far been admitted. Perhaps it would be well for me to commence by putting in plain words what I really intend to convey by this term in order to avoid confusion. The word "abortive" in this connection must not be understood in the sense in which it might be interpreted after eradication of the chancre supposing, for the sake of argument, that this procedure really held out hope of attaining its object. Surgical treatment which would at the same time remove the cause and obviate the effects would indeed have been ideal, but unfortunately such is not the case.

The abortive treatment of syphilis in the sense I intend must be interpreted with a much wider scope, in fact, we must allow the term a certain elasticity. It consists of medical treatment which by energetic and rapid mercurialisation from the very onset prevents the generalisation of the spirochæte in the organism, shuts up the infection *in loco*, and restricts it to the chancre with limited glandular enlargement, subsequently weakening the infection until ultimate extinction in such wise that no secondary manifestation makes its appearance in spite of the closest search and observation.

In patients thus treated, therefore, we never get any roseola or general glandular enlargement, or alopecia, or mucous patches, or leucoderma, in short, none of the clinical symptoms by which we are enabled to diagnose the generalisation of the disease in the economy. Lymphocytosis in the cerebro-spinal fluid has also been absent in the cases that have been observed. It is indeed the curative and preventive properties of mercury pushed to their uttermost degree. It appears to me that the term "abortive" is justified by contrast with the other methods which admit recurrence as a general rule.

I have subjected altogether 134 patients to this mode of treatment, 120 men and 14 women, their ages varying from 16 to 36 years. Among these 134 cases six were doubtful, presenting certain ill-defined throat symptoms. The conditions of success of the abortive treatment are the following:—

(1) The treatment must be commenced before the twelfth day following the appearance of the chancre.

(2) The treatment entails the employment of injections of insoluble salts, or calomel, or what is more practical, grey oil, in intensive doses.

(3) The first course of treatment should be pushed to the utmost degree compatible with the resistance of the organism, and continued for not less than four months.

(4) The subsequent courses of treatment comprise shorter periods, on the lines of the chronic intermittent treatment of syphilis.

1.—THE TREATMENT TO BE COMMENCED BEFORE THE TWELFTH DAY.

Experience seemed to indicate the twelfth day as the limit for the certain, abortive treatment of syphilis, nevertheless I have myself successfully carried out the treatment in a case of chancre of 17 days' standing. That is a matter of judgment, and there is considerable difficulty in exactly establishing the extreme limit for the success of the treatment, and it is quite conceivable that other observers may find it feasible to extend this period. In any case the limit cannot possibly be the same in all patients, for no one will contest that the generalisation of the spirochæte takes place with very variable rapidity in different subjects, and that the conditions of microbial virulence and organic resistance must influence the duration of the period of generalisation.

The necessity for prompt treatment and the value of the preventive action of mercury, still questioned by some observers, are amply confirmed by the results of the abortive treatment. By pills and inunctions given from the onset we can at most hope to delay and mitigate the roseola, reducing it maybe to a few scant manifestations, whereas by a more energetic treatment, such as the abortive method, we may obviate it altogether. It must, however, be borne in mind that if instead of inaugurating immediate treatment we await the appearance of the roseola the same treatment, although applied with the same energy, will not succeed in jugulating the attack, and this fact, better than all the heresies put together, illustrates the capital importance of the epoch at which the treatment is begun. The possibility of cutting short an attack of syphilis had already been foreseen by my friend and master, Prof. Jullien, who has published several observations of the kind. All I have done has been to systematise his ideas, and I flatter myself that my efforts in that direction have been successful.

In early mercurial treatment there is one great rock ahead, viz., error of diagnosis. I believe, however, without arrogating to them the gift of infallibility, that syphiligraphers upon whom long experience has conferred the *tactus eruditus*, who scan with every care the incubation period and the appearances, have an immense superiority over the ordinary practitioner, and experience no hesitation under circumstances where others would be greatly embarrassed. In a really doubtful case I should be the first to hold my hand and await the appearance of the roseola. Of late, however, such cases have been getting rarer and rarer, and the chances of error have greatly diminished now that the recognition of the spirochæte affords us a new and unquestionable basis of diagnosis.

2.—METHOD OF APPLICATION AND DOSES.

If I early made up my mind only to use insoluble salts for injection in carrying out the abortive treatment, it was because experience had shown me that in practice this method alone possessed the qualities indispensable for the success of the treatment. I do not pretend that, theoretically, at any rate, inunctions and soluble injections might not attain the same end. But inunctions present certain drawbacks and shortcomings. They do not display the same activity in all subjects, and are open to various objections which it would be tedious to enumerate here. Daily injections of soluble salts become so irksome for the patient, and are often so painful in intensive doses, that these two methods can but rarely be found suitable in daily practice; moreover, they only imperfectly realise the abortive treatment. Soluble salts, moreover, present the very great disadvantage that they are too rapidly eliminated without having liberated their mercury constituent, and without having adequately permeated the cells of the organism. Indeed, for the results of the two to be made comparable, we should have to employ a method of uniform activity which would not be liable to numerous sources of error. Although the injection of insoluble salts is itself by no means exempt from drawbacks, it does assure the regularity of therapeutical effects as witnessed daily in our clinic which it will not occur to anyone to question at the present time.

The best method, then, is by the injection of insoluble salts, which enable us to obtain the desired results by methodical and scientific mercurialisation, without interfering with the patient's social and family life. Inasmuch as the abortive treatment ought not to be reserved for exceptional cases, but, on the contrary, should be employed whenever the opportunity presents itself, the therapeutical agent we make use of must be one readily accepted by the patient. The preparation that best fulfils this condition from every point of view is grey oil. It is, indeed, the preparation that appears to be most popular with syphiligraphers, who are in favour of insoluble injections, and their preference is justified by the fact that this preparation yields the best possible results, and has enabled me to carry out the abortive treatment in 134 instances, with only six doubtful cases.

3.—THE MAXIMUM INTENSITY OF THE FIRST COURSE OF TREATMENT.

Then, too, the method of insoluble injections realises better than any other the possibility of intensive treatment which is indispensable to its success. It is just when the virus is beginning to multiply that it behoves us to attack it with the greatest possible energy, and on the intensity of the first course of treatment will depend the ultimate course of the disease. It may be that in the subsequent courses of treatment less energetic means can be employed, and that inunctions and soluble injections may suffice to annul the virus once it has been mastered by the first course.

But for this first attack of the diathesis the application of mercurialisation must not be in the least attenuated. It must be pushed to the limit of organic resistance, and my experience has satisfied me that it is always necessary to give not less than 15 or 20 injections, entailing a course of about four months. The first three injections must be made at intervals of five days, the next three every six days, and the remainder at intervals of eight days. Each of these injections comprises a Barthelemy syringeful of grey oil at 40 per cent., which is equivalent to 0.14 centigramme of metallic mercury. These doses are calculated for adults of an average weight of 65 kilogrammes.

4.—TREATMENT TO BE CONTINUED ON THE LINES OF THE CHRONIC INTERMITTENT TREATMENT OF SYPHILIS.

During the two years following, I give ten or twelve weekly injections at intervals of two months. During the third and fourth years I give eight or ten injections at intervals of three months, but, as I shall explain later, I am by no means convinced of the necessity of treatment during the third, and especially during the fourth year, and if I have hitherto adhered to this plan it was merely in order to leave nothing to chance.

It may be objected by timid practitioners that there is more danger in pushing mercury in intensive doses than in allowing the development of a slight roseola; they may suggest that it would be safer to proceed with less haste rather than run the risk of mercurial intoxication. As a matter of fact, no such intoxication takes place provided one is careful to make sure of the integrity of the emunctories, and those who have visited my clinic have been able to satisfy themselves of the perfect tolerance of my method. Nor are we justified in employing this big word intoxication merely because there happens to be some slight discomfort, any more than we have the right to ascribe any lassitude and pallor exclusively to the influence of the treatment.

It may be conceded that mercury can never be a food, but neither will syphilis ever become a welcome disease, and assuredly we are more interested in ridding the organism definitely of such an enemy than in taking precautions lest the mercury should determine sundry slight inconveniences, which, moreover, are easily remedied. We see our patients during the intervals of the intensive treatment not only make good the weight they have lost, when there has been any loss, but even put on more flesh. This clearly proves that if there be any intoxication it is less than would be provoked by the generalisation of the virus of syphilis, so anæmiating in its nature, and of two evils it behoves us to choose the lesser.

Moreover, it would be absurd in the extreme to look at the matter from such a narrow point of view, and to overlook the fact that the roseola, as well as the local lesion, though admittedly of trifling gravity, is at the same time an unquestionable sign of constitutional infection. To allow the syphilis to run its course, says Jullien, when it is within your power to stop it, is to adopt an attitude of abnegation which nothing in therapeutics can justify, and the consequences whereof will weigh heavily on the whole subsequent course of the disease.

If the toxins of syphilis really play the part with which they are credited, would it not be supremely illogical to permit the development of these poison-producing agents of whose deleterious effects we are still imperfectly cognizant. The slight importance that used to be attached to the roseola has imbued many practitioners with another false idea, viz., that of making it a sort of criterium of the virulence of the attack and of regulating the energy of the treatment thereby.

Another very erroneous conception in respect of the syphilitic exanthem, which may explain the slight concern with which many regard it, is that syphilis at the secondary period is a purely cutaneous disease, oblivious of the fact that there may be many graver exanthemata than the one which is visible to the eye.

We know since Ravaut's works that roseola is not infrequently associated with cerebro-spinal lymphocytosis, and we are also aware of the refractoriness of syphilitic affections of the nervous system to medication. Can it therefore be a matter of indifference to allow the spirochæte, at the period of its first virulence, to attack the meninges and the cerebro-spinal centres the absolute integrity whereof is indispensable to the harmonious working of all the organs?

Lumbar puncture will render it possible for us to recognise the fact that the meninges are being involved, and if we are fortunate enough to have made the puncture early, we may be able to cut the process short. Moreover, it would be contrary to all clinical principles to allow an infective malady like syphilis to develop in the organism, and the routine practice of waiting for the appearance of the roseola before commencing treatment ought to be abandoned once and for all. It has, indeed, always been based on errors of observation. Lumbar puncture carried out on ten patients who had followed the abortive treatment only revealed physiological lymphocytosis, showing that the meninges had escaped injury.

In another patient who had had the roseola, puncture was made after his first intensive course of treatment, and microscopical examination revealed the past existence of lymphocytosis, characterised by the presence of degenerated deformed elements the nuclei whereof took the stain imperfectly. I am absolutely convinced that patients whose cerebro-spinal centres have been protected against the initial development of the diathesis will be less liable than others to subsequent syphilitic affections of the nervous system.

The abortive treatment should be employed at every opportunity, just as, speaking generally, the intensive treatment is applied to all syphilitics who are in a condition to support it. Not, however, that I wish to question the existence of benign forms of syphilis—benign, that is, either by reason of the diminished virulence of the organism or the enhanced resistance of the subject, but what I do deny absolutely is that there is any possible means of identifying these forms beforehand.

We may be asked whether the abortive treatment of syphilis will enable us to shorten the duration of the treatment. It is only logical to suppose that such is the case, although we are at present unable to bring any clinical proofs thereof. There are several patients whose treatment was abandoned after the second year, but as the problem is difficult and its solution wholly empirical, time alone will enable us to obtain the data on which to base a trustworthy conclusion.

If the old-fashioned methods of treatment, applied methodically during a period of four years, succeeded, in spite of many shortcomings, in reducing the proportion of tertiary patients in Professor Fournier's hands to 3 per cent., it is only logical to suppose that, as this result was attained in cases of syphilis in which constitutional infection had been shown by roseola and subsequent outbreaks, common sense would tell us that we can cure syphilis at less cost when it has, so to speak, been circumscribed from the commencement, and has been energetically fought throughout.

But the question acquires special interest, and demonstrates all the advantages of the intensive treatment, if we bear in mind that at least 25 per cent. of the patients treated by the old-fashioned methods give up treatment after the second year, in spite of our warnings, and that under these conditions the proportion of tertiaries is no longer 3 per cent., but, according to the same statistics, rises to 17 per cent.

A very important question arises at this juncture, viz., whether in the doses indicated the method is practically applicable—in other words, does it not entail drawbacks which more than compensate for its advantages as just described? Here are my figures. In my clinic about 15 per cent. of the patients cannot tolerate it, but in private practice only about 5 per cent. are unable to carry it through. The method, it may be urged, is painful; well, there may be some pain on the third day, but it is usually quite bearable and in most instances it is *nil* or merely trifling. A French physician once asserted that it was the puncture that should be painless rather than the salt injected, and it is for the practitioner to train his hand and acquire the necessary dexterity, for it must be admitted that but too frequently the injections are badly done, and that the pain as often as not is the fault of the operator.

It may be followed by abscess. Grey oil but rarely gives rise to abscess formation, but the practitioner not infrequently does for want of antiseptic precautions and suitable instruments, and I have on various occasions carried out without a hitch, to the patient's great surprise, a course of treatment which had been inaugurated by several abscesses.

During the last twelve years I have made considerably more than 10,000 injections, and I have only had four aseptic abscesses with calomel and four following grey oil. Embolism can never take place with a properly-applied method if we are careful to wait twenty or thirty seconds before making the injection in order to make sure that no blood trickles out of the needle.

As to symptoms of poisoning I have never met with anything at all serious. It is by no means rare for some discomfort to be complained of at the end of the course, but the symptoms soon clear up.

Stomatitis exists whatever method be employed, and it is very important to attend to the state of the mouth in every instance in which mercurial treatment is adopted. The dose of 0.14 centigramme of mercury for a person of average weight need not excite any alarm and it is well borne. This ought to be the average dose, for in the past we have always been giving far too little mercury to our patients.

I have shown before various Belgian societies extensive series of patients who had gone through the course of 15 or 20 injections of 0.14 cg. of mercury whose general health was excellent, who did not present any nodules in the gluteal region and whose mouths were free from the slightest trace of stomatitis. It is obvious, however, and this condition is indispensable to the success of the abortive treatment, that *the method infers the absolute functional integrity of the principal viscera*, of the liver and, more particularly, of the kidneys. In every instance the urine must be examined *before each injection*.

This method is formally contra-indicated in *the aged, the cachectic, chronic alcoholics with renal insufficiency, in arterio-sclerosis and the subjects of plumbism and gout, in the tuberculous, and in pregnant women with albuminuria*. Children bear the treatment well, the doses of course being proportionately reduced.

The abortive method, apart from the advantages which it presents in respect of the individual whose diathesis is thus sterilised, also constitutes a very advantageous method for the protection of society since, by obviating all contagious manifestation, it realises better than any other measure the prophylaxis of syphilis.

OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Minor Degrees of Shock.

By Leonard Williams, M.D., M.R.C.P.,

Assistant Physician to the Hospital, Physician to the French Hospital in London.

This young man, whose age is 20, comes here complaining of the vague subjective sensations which are so commonly labelled neurotic or hysterical. He has nothing more definite to tell us than that he is "not sure of himself," "is afraid to go out," "feels all of a shake." When questioned, he says that he has no appetite and that he is sleepless. Further cross-examination elicits that these discomforts all came on suddenly three days ago, after he had had a fright. The fright was a serious one. It was caused by his elder brother, who had come home from an asylum, suddenly becoming acutely insane and escaping from home.

In the out-patient room we are rather too apt to be incredulous of the reality of the vague subjective sensations of which we hear so much from women; and the case of this young man is a good instance of the injustice we sometimes do when we dismiss these complaints as fanciful and unworthy of serious attention. It also illustrates the value of inquiring for a history in every case, however unimportant it may seem. The events which preceded this youth's neurotic attack were sufficiently alarming. They were, indeed, such as might easily upset people of the most robust organisation. His subjective sensations are evidently very real, for he is suffering from a perceptible degree of what is called shock. Physical examination does not tell us very much. He has dilated pupils, it is true, but they are equal, and react to light and accommodation. His deep reflexes are, no doubt, exaggerated, but there is no evidence of any organic disease in his nervous system. I did not expect to find any, but inasmuch as a great many organic nervous diseases show themselves by very typical "functional" manifestations, it is never safe to take for granted that physical signs are absent. More especially is it necessary to be careful in patients of this young man's age, because, of all organic nervous affections, that which is most commonly diagnosed as functional is disseminated sclerosis, and this youth is just at the age when this disease would be most likely to show the first evidence of its presence.

Now what do we mean when we speak of shock? The term shock, used surgically, conveys a very definite picture to those of us who have witnessed severe degrees of it; but used medically, and especially used socially, its significance is of the vaguest. I think, in reality—that is, pathologically—the term as thus variously applied means the same thing, only in different degrees. The essential condition in surgical shock is a generalised dilatation of the arteries. The muscular coats are no longer in the state of partial contraction which is called "tone"—the state in which they are on the *qui vive*, so to speak, to obey an order either for contraction or dilatation. They are flaccid and inert, with the result that the pressure of the fluid within the vessels becomes very much lowered, and the blood stream dangerously sluggish. It is the medulla which keeps the arteries in tone, so that if tone is absent, we must suppose the medulla to be either asleep or unduly exhausted. The medulla never sleeps, any more than the heart does, but it is often exhausted. Over-stimulation exhausts it, as in severe abdominal operations and other conditions in which the sensory nerves have been placed strongly on the rack for a long period. For the first effect of irritating a sensory nerve is to stimulate the medulla, and this produces constriction of the arteries. If the irritation of the nerve is prolonged, the medullary stimulation is also prolonged, and may be prolonged to the point of exhaustion. When this happens, the medulla is no longer able to maintain the tone of the arteries, and the vessels relax. If they relax to their fullest extent and remain so for any length of time, the blood stream becomes so sluggish that the blood does not reach the brain in sufficient quantities, and the patient dies. Fortunately, this does not often happen, but it is no uncommon thing for lesser degrees of medullary exhaustion to take place. Perhaps we ought to confine the word exhaustion to extreme degrees, and speak of the lesser degrees as medullary fatigue. Such a term does not, however, convey at all accurately what has happened in this young man's case. Here the medulla has had a "shake"; it has been subjected to a sudden violent storm, with the result that it is neither exhausted nor in reality fatigued, but its equilibrium is upset. It is still capable of reacting, but its reactions, instead of being measured, controlled, and smooth, are violent, spasmodic and jerky.

Thus it is that an estimation of this lad's blood-pressure showed a figure (120 mm. Hg.) which is normal, and when we counted his pulse in the upright and recumbent postures we failed to find the very decided increase in rate on standing which we should expect to find in a case where the medulla was really fatigued and the blood-vessels consequently in a state of undue dilatation. The medulla is always in this irritable state in hysterical or neurotic people, whose blood-pressures, therefore, present the most extraordinary vagaries. The mere fact that the patient is being examined by two or three doctors is sufficient to elevate it unduly. If we could only catch these cases when they were "themselves," uninfluenced by mental stimulation, we should find the pressure low—sometimes very low. It is then that, like Iphigenia, they deplore their fate; but let there come a stimulus, and up mounts their blood-pressure, filling them with intense ambitions to reform the world and all its contains, except, of course, themselves, who, in their own view, require no reforming. This eccentricity of blood-pressure never occurs in the condition which is so frequently confused with hysteria—namely, neurasthenia. In neurasthenia the pressure is uniformly and consistently low, and is conspicuously unresponsive to ordinary stimulation. True neurasthenia is, in point of fact, a species of "shock" in which the medulla is fatigued indeed, but not primarily, as in ordinary shock. In neurasthenia the medullary fatigue is secondary to fatigue of some of the other cerebral centres.

To confirm the suspicion that, except when subjected to the stimulus of being examined, this lad's arteries are in a state of dilation, I examined his urine, in which, as you saw, there was a distinct cloud of albumen. Dilatation of the arteries causes the blood to stagnate in the splanchnic area, and this gives rise to a passive renal congestion which, in its turn, will produce an albuminuria. Such, as I have often explained, is the train of events which is responsible for cyclical or postural albuminuria. The presence of albumen in this lad's urine is therefore strongly confirmatory of the view that, in spite of the verdict of the manometer, his arteries are unduly dilated.

The treatment of these cases is simple enough. We will take this patient into the wards, and in a few days his medulla will have recovered from its shake and will once more be working smoothly. If we are to treat him with drugs, these must be of the sedative type. Bromide of potassium and valerian will do him good by helping him to re-establish his medullary equilibrium. Tonics he does not require; they would, indeed, do him harm. More especially ought we in these cases to avoid strychnine. Strychnine acts by stimulating the medulla, so that it is obviously peculiarly ill-adapted to the treatment of a case in which the medulla is already in a state of undue irritability. If he were a rich man instead of a poor one, it would be well to send this patient to some spa or institution where he would, in practised hands, be treated by cold water baths and douches. In chronic neurotic cases, more especially, these baths do an enormous amount of good, and the place at which they are best administered is Divonne, close to the Lake of Geneva. It is as well to remember in connection with this place that it is a summer resort. I have known people sent there in mid-winter with results not altogether favourable

OPERATING THEATRES.

HOSPITAL FOR SICK CHILDREN, GREAT ORMOND STREET.

Case for Diagnosis.—Suprapubic Cystotomy.—Mr. Edred Corner operated on a little girl, æt. 10, who had been admitted suffering from symptoms which pointed to disease of the bladder. The history of her illness dated from the time when she was three years of age. During this period of seven years she had been seen by many doctors, and treated as an in-patient at many hospitals throughout the Thames Valley. Briefly, Mr. Corner said her symptoms were: pain and frequency of micturition, aggravated by exercise and improving whilst lying up. On several occasions she had passed blood in her urine, but this was most frequent at the commencement of her illness, and had not occurred during the last two years; the urine, on examination, contained pus and albumen. The diagnosis made previous to her admission to Great Ormond Street was tuberculous disease of the bladder, which diagnosis was arrived at rather by a process of exclusion than on account of any positive evidence being found in its favour; no tubercle bacilli had been discovered in the urine. The child was taken to the operating theatre and examined under an anæsthetic. The bladder was first washed out, and then examined with the stone sound. The end of the sound in the bladder could be felt to impinge upon some resistance, which did not give either the sensation or the sound which a stone usually does; yet, whilst washing out the bladder, that organ had been easily distended, so that it was impossible that the resistance felt could have been due to the sound meeting the bladder wall. The bladder was again washed out, and the cystoscope passed, when the walls of the viscus were seen to be much trabeculated. A little further examination revealed the presence of a large stone free in the bladder, its surface being thickly covered with phosphatic deposit. It was impossible to gauge the exact size of the stone, because only a small portion of it could be seen at one time in the field of the cystoscope. This stone was evidently the explanation of the long history of vesical symptoms. It was thought that the stone was too large to be crushed with the lithotrite, so the bladder was again distended and a vertical incision made in the middle line just above the pubes, the anterior sheath of the rectus muscle opened, the recti abdominis muscles separated, the peritoneal pouch in front of the bladder carefully drawn upwards, and the bladder wall exposed. The bladder is, Mr. Corner pointed out, easily recognised by its colour and the tortuous veins which run on its surface more or less parallel to the incision. It is often easy to expose the bladder suprapubically in children, as in them that viscus is placed higher and more in the abdomen than it is in adults. Two guide stitches were passed through the bladder wall, which was incised between them; a finger was passed through the opening, and the large stone immediately felt. The next step in the operation was technically the most difficult of the whole proceeding; it was to grasp the right diameter of the stone in forceps and deliver the calculus from the bladder. This, Mr. Corner said, is easy when the stone is small, but may take some time when the stone is very large. The incision in the bladder was not closed, but each side was attached to the corresponding rectus muscle with a catgut stitch. Mr. Corner remarked that it is advisable to do this when the opening in the bladder is merely for temporary purposes; if the opening is to be for some time, then the bladder had better be sewn to the anterior rectus sheath or to the skin. A rubber tube was placed in the bladder through the lower part of the incision, and the catgut stitches tied together, so as to close the opening in the bladder wall round the tube. The anterior rectus sheath in the upper part of the wound was brought together with a few catgut stitches, as was also the skin. A gauze plug was placed in the lower part of the wound round the tube in the bladder. By this means, Mr. Corner said, the bladder would be drained by syphonage for three days, when the rubber tube would be taken out. Mr. Corner remarked that it seemed inconceivable that this stone could have been free in the bladder for the seven years during which the child had had vesical symptoms, and that it could have been unrecognised by so many medical men. Her pain and misery had reduced the girl, who was fair, to that thin and delicate condition so often associated with advanced tuberculosis. Her appearance, and the inability to ascertain definitely the cause of her illness, had led the diagnosis of tuberculosis of the bladder to be made; and he would suggest that this stone must have been hidden in a pouch of the bladder during the greater part of the period of her long illness; hence its presence could not be ascertained with a sound. There were three important lessons to be learnt from consideration of this case: first, the sound may be an uncertain instrument to depend upon for the diagnosis of stone in the bladder; secondly, the cystoscope may be of the greatest use in arriving at a correct diagnosis; thirdly, and from the point of view of the surgeon dealing with cases in children, a skiagraph should have been taken. The omission to take this step (almost invariably omitted by students in examinations), which must have demonstrated indisputably the presence of this huge calculus, would have saved the patient from the loss of health, education and vigour such as resulted from the last six years of her illness.

Medical Agreement.

At Pwllheli Board of Guardians meeting on November 20th, a letter was read from the six public vaccinators offering finally to settle the dispute as to the vaccination fees, and they agreed to accept 5s. per case, plus 1s. registration fee; but in the Aberdaron district, which is the remotest part of Lleyn Peninsula, a fee of 6s. was asked for, plus 1s. for registration. The board's offer was 5s. 6d. inclusive, and this they decided to adhere to. Failing acquiescence by the next meeting, the board will take steps to fill up the places.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Obstetrical and Gynæcological Section.

Meeting held Thursday, November 14th, 1907.

The President, Dr. Herbert Spencer, in the Chair.

Dr. Thomas Wilson read a paper on

PUBIOTOMY,

with notes of an illustrative case. The paper was published in our last week's impression. In the discussion that followed,

The **President** said he had no personal experience of pubiotomy or of symphysiotomy, preferring the alternative operations of induction of labour and Cæsarean section. The operation of pubiotomy had been rarely performed in Britain, but Dr. Wilson had omitted two cases operated on by Dr. Wallace, whose opinion of the operation was "not an entirely favourable one." The President thought that Dr. Wilson had not sufficiently emphasised the dangers of the operation. Baumm's two cases terminated fatally, and Robert Mann had published a case of hernia through the gap in the bone. Injuries of the bladder and vagina and thrombosis were not uncommon accompaniments of the operation, and, if not fatal, involved considerable risk. He did not think a rest of 16 days in bed was sufficient for the proper consolidation of the bone. Dr. Wilson's case occurred in a patient with a pelvis of almost normal size, and though he did not question the justifiability of the operation in this case, the special dangers of laceration of the vagina would be much greater when the pelvis was considerably contracted. Operators seemed to be divided in opinion upon the question of immediate or deferred delivery; but he thought it would be unjustifiable to submit a patient to the pains of labour after the bone had been divided unless she were kept continuously under an anæsthetic, which itself involved risk. Although the mortality of pubiotomy was not high, it probably was at least as high as induction of labour and Cæsarean section, and involved dangers which appeared to be unavoidable, and disabilities to the mother, which were not met with in the alternative operations. With regard to Pinard's views on the treatment of contracted pelvis, he would say something on another occasion. Meantime, his recollection was that Pinard had with symphysiotomy lost 12 per cent. of the mothers and children. Pinard's latest statistics, mentioned by Dr. Hubert Roberts, showed a maternal mortality in symphysiotomy of over 11 per cent., and an infantile mortality of 14 per cent. They also showed a growing faith in conservative Cæsarean section and a lessening faith in symphysiotomy.

Dr. **Macnaughton-Jones** said that, like the President, he had never had recourse to symphysiotomy. At Heidelberg Prof. v. Rosthorn had given him the details of a case in which uncontrollable and fatal hæmorrhage had occurred after pubiotomy. When he was in Freiburg in 1906, Prof. v. Krönig had performed 30 cases without a death, and had lost two children. On the other hand, Franqué, up to March, 1905, had operated 43 times, with 12 deaths and the loss of three children. Schauta, in his recent work, seemed to favour pubiotomy. The higher the head, Krönig had pointed out, the greater the danger to the bladder. The advantages over symphysiotomy seemed mainly to be the avoidance of hæmorrhage and of injury to the structures in the median line, as the clitoris and urethra; but Zweifel and others considered that the permanent effect, so far as pelvic uniformity and general gain of increase in diameter are concerned, was better in symphysiotomy than in pubiotomy.

Dr. **Griffith** referred to the great difficulty there is in discussing and comparing records of the operations of pubiotomy and symphysiotomy, owing to the different views held by different operators as to the condition which justified the operation. His own experience was confined to symphysiotomy, and he was of opinion that pubiotomy presented no real advantages, while symphysiotomy was simple, and required no special instruments. The difficulties, in his opinion, were not in the operation but in the proper choice of cases for which it was suitable. Those operators who, like the late Dr. Varnier, declined to use forceps, premature induction of labour, and any other means than symphysiotomy for every case of even slight difficulty, obtained a large number of good results both as regards mothers and infants, but this was a line of practice that does not appeal to English obstetricians. He hoped the time would come when it would be generally recognised that the treatment necessary in cases of obstruction at the brim was not to be determined by the length of the conjugate unless in extreme degree of contraction. In these cases Cæsarean section was the only method, but in all the common, slight, and moderate degrees of contraction, the length of the conjugate, while a very important factor, was never the determining factor. It was no uncommon experience to see a woman spontaneously delivered with a conjugate of about 3¼ inches, without danger to herself or her baby, while in other cases, with a conjugate half an inch longer, the difficulty and danger may be great, this depending first on the size of the child's head, a favourable position of the head in relation to the obstruction, the mouldability of the head, and the power of the uterus; and it is in the correct judgment of these difficulties that the obstetrician of experience will be able to differentiate and select those few cases to which, in his opinion, the operation should be confined.

Dr. C. **Hubert Roberts** wished to add his testimony to that of Dr. Griffith with regard to the importance of endeavouring to estimate the size of the fœtal head in contracted pelvis, and not merely depending on the actual bony measurements of the pelvis itself. As to pubiotomy and symphysiotomy, Dr. Roberts thought that possibly these operations had sprung into favour abroad largely on account of the falling birth rate. The latest statistics of Pinard, in the "Annales de Gynécologie et d'Obstetrique," for September, 1907, showed this very forcibly, and in France, at all events, it would seem that the induction of abortion and premature labour in contracted pelvis had been given up. Hence the frequent performance abroad of such operations as pubiotomy and symphysiotomy, especially the latter. Dr. Roberts had performed subcutaneous symphysiotomy once at Queen Charlotte's Hospital, with good results to mother and child. He had no experience of pubiotomy.

Dr. **Thomas Wilson**, in reply, thanked the President for referring him to Wallace's two additional cases, which brought the total number of pubiotomies performed in this country to ten. Where, after dividing the bone, the labour is left to the natural efforts, it does not appear to be necessary to keep the patient anæsthetised. The pain following operation in Dr. Wilson's case was moderate, and this appears to be the rule. Time must show whether symphysiotomy or pubiotomy is the better operation. The latter appears to possess over the former the advantages of being less liable to cause severe bleeding, of endangering the bladder to a less, and the urethra to a much less, degree. It is remarkable that no discussion on pubiotomy had previously taken place in London, and that no one in this city appears to have put the operation to a practical test.

The following specimens were shown:—

Dr. **Herbert Spencer**: Squamous carcinoma of the cervix in a patient, æt. 26. High amputation with cautery. Patient shows no recurrence six and a-half years after.

Mr. **Alban Doran**: Ovarian dermoid retained two years in the pelvis after obstructing labour.

Dr. **Fairbairn**: Fatal rupture of an early tubal pregnancy.

Dr. **Macnaughton-Jones**: An improved demonstration pelvis.

Dr. **Thomas Wilson**: Unilateral hæmatometra recently acquired by operation.

Dr. C. E. **Parslow**: Pregnant uterus with fibroid, the latter in a state of red degeneration.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Medicine.

Meeting held Friday, November 8th, 1907.

The President, J. M. Redmond, in the Chair.

FUNCTIONAL SPASTIC PARAPLEGIA.

Dr. **Craig** exhibited a coachman, æt. twenty-three, who had been admitted to the Meath Hospital in March, 1906, complaining of pain, coldness, and a dead feeling in his left leg. He attributed his condition to a wetting, received a year before, when he wore a broken boot. A sensation of "pins and needles" in his left foot and leg followed. Subsequently cold sweats occurred in the leg accompanied by pain which passed up his side into his left arm. Later the pain again attacked and settled in the calf of his left leg, while from the hip down the limb was cold and numb. Tremors then appeared in the leg, so that on attempting to walk he staggered like a drunken man; spasm of the muscles in the leg and extension of the tremors to the other leg and to the arms followed. Examination revealed increased knee jerks, some attempt at ankle clonus in the left leg, slight nystagmoid movements of the eyeballs, no slurring of speech, rhythmical tremors appear in the limbs on using them. He was thought to have disseminated sclerosis, and left hospital in about six weeks without any change in his condition. He weighed 10st. 2lbs. on leaving hospital in April, 1906. The patient came into hospital again about a month ago, this time under Dr. Craig's care. He now attributes the onset of his illness to his having slept on a mattress on a stable floor while nursing a sick horse. He says his legs and left arm are weak, and that he has shooting pains which run up his legs, along his sides, across his chest and down again. In the left arm he has shooting pains which escape by the tips of his fingers. He is now only 8st. 7lbs., and appears to be wasted, but the wasting is quite general. He is unable to stand with his eyes closed, and staggers considerably when walking, knee jerks are increased, there is no ankle clonus, but on the left side a few spasms of rectus clonus are elicited which give him pain. There is a flexor plantar reflex. Hyperæsthesia to touch, pain and heat is universal. He has a fairly coarse tremor, seen well in his arm when he places a forefinger on the tip of his nose. He has very slight nystagmoid twitches on extreme lateral movement of the eyeballs. Sir Henry Swanzy reported that otherwise his eyes are perfectly normal in every respect. There is no trouble connected with either bladder or rectum. During his previous stay in hospital the diagnosis of disseminated sclerosis was undoubtedly made on the weakness of the legs with increased knee jerks, the tremor and the nystagmoid twitchings. The case is, however, a functional one. The pain and numbness complained of early in 1905 were probably due to sciatica. When he came into hospital on the present occasion ataxia was the most prominent feature of the case—to-night he is free from ataxia. The knee jerks are also less responsive, and even the tremor is not so marked. This morning it was quite absent from both arms. When now examined he exhibits to-night, for the first time, a spurious clonus in the right leg. It is due to spasm of the thigh muscles; the ankle is quite unmoved. On rubbing his forehead with a forefinger or on gently pulling the hairs of his legs he complains of pain. The hyperæsthesia is quite general. The points, however, upon which Dr. Craig most confidently relied in pronouncing against the existence of an organic lesion in the brain and cord are—(1) absence of ocular signs, such as optic nerve atrophy, contraction of the field of vision, limitation of muscular movements; (2) absence of any involvement of the bladder and rectum; (3) absence of true ankle clonus and toe-extension phenomenon. Hyperæsthesia is less common in purely hysterical cases than anæsthesia, but taking this symptom of general hyperæsthesia with the loss of flesh and the general aspect of the patient, Dr. Craig regarded his condition as neurasthenic rather than hysterical—in fact the case presents that alluring symptom group which is so frequently found in people who have received an injury for which compensation is expected. The patient was exhibited to-night in order to draw attention to the importance of making an accurate diagnosis in cases exhibiting nervous disturbances, because of the important differences in the prognosis between an hysterical or functional paraplegia like the present one and a case of, say, disseminated sclerosis. The man has been taking valerianates for the past ten days. Dr. Craig had told the patient that he will get well, and already he was much impressed with the improvement that has taken place, and which he confidently expects will be continued.

Sir **Christopher Nixon** said it would be difficult to conceive that a case which presented such varied disturbances from the normal could be regarded as simply functional in character. He thought the term functional paraplegia was open to grave objection. It did not explain in any way the multitude of symptoms in the case. At first it undoubtedly showed the ordinary symptoms of disseminated sclerosis. There was more about the man than simple functional disturbance; and, while he had the greatest respect for Dr. Craig's acumen in diagnosis, he claimed that there was always room for latitude in nervous diseases, and expressed the opinion that the case was one of disseminated sclerosis undergoing a period of remission.

Dr. **Drury** said he had seen the case before, and could bear out Dr. Craig's statement that the symptoms were different then from ten days previously. He did not think, however, that they could altogether depend on the absence of bladder symptoms as necessary early in diagnosis. In nearly all chronic nervous cases very marked functional manifestations appeared. He did not think that any of them could either condemn the patient as being a case of organic disease or buoy him up with the idea that it was merely functional unless they had gone into the case with greater fulness, and they might depend on the diagnosis of Dr. Craig, who had studied the case.

Dr. **Travers Smith** said that if he had to give a working opinion of the case he would give the same as Dr. Craig, and he believed the patient would get well. By that he would imply the loss of function of some portion of the nervous apparatus, without any discoverable anatomical change to account for it. He did not think they need be afraid of diagnosing functional disturbance while still keeping their minds open to the possibility of its being only preliminary to permanent disturbance. He thought that the very rapidity of the changes that had occurred in the case, as well as present symptoms, were all in favour of functional disease.

Dr. **Walter Smith** said that in their present hazy state of knowledge of many aspects of nervous disease, he would hesitate to pronounce a definite opinion as to the exact state of the case, but he shared Sir Christopher Nixon's objections to the use of the word functional, which, he hoped, before long would vanish from medical nomenclature. If a term must be used, he would prefer the word hysterical, which connoted a state of things better than functional. Stress had been laid on the point that if the patient got well, the diagnosis of functional disease would thereby be substantiated, which was as much as saying that if the patient had organic disease he could not get well, and therefore recovery would make a different diagnosis—a line of argument which was quite unwarrantable. The recent demonstration that the nerve-supply of the bladder and rectum was not derived from the lumbar region should modify their consideration of the matter, and he would hesitate to accept Dr. Craig's diagnosis as absolutely correct.

Dr. **Moorhead** said he had seen the case previously, and had disagreed with Dr. Craig's diagnosis, but he had since come to think that the disease was functional.

Dr. **Purser** discussed the site of functional degradation in this case.

Dr. **Craig**, in reply, said he did not regard the absence of bladder symptoms as of vital importance, but in nearly every case of disseminated sclerosis with pronounced symptoms bladder symptoms were present. He only dwelt on the absence of such symptoms because it was in combination with the absence of ocular phenomena and ankle clonus.

EXHIBITS.

Dr. **Winter** showed a case of amyotrophic lateral sclerosis. The patient was a coachman, æt. thirty-eight, who, about six months before he first saw him, noticed that he was wasting between the thumb and first finger of the right hand; he did not then notice any weakness. Since that time atrophy of the muscles has proceeded rather rapidly, the muscles chiefly involved being those of the right hand, the extensor of the right wrist, and the deltoid and triceps, but there is also some wasting of the muscles of the left hand. A very well-marked feature of the case was the fibrillary contraction of the muscles, which was present in the muscles of both arms, and also both pectorals and the scapular muscles. There were no bulbar symptoms. In addition to his muscular atrophy the patient showed exaggerated knee jerks and sometimes ankle clonus, the reflexes in his arms being also exaggerated, but beyond the facts elicited by examination the patient showed no spastic symptoms, and although at first sight the case looked like one of progressive muscular atrophy Dr. Winter thought that the name under which he had exhibited the case gave a better idea of the conditions that were found, and, in his opinion, the case tended to confirm the view that the two conditions were identical.

Dr. **Travers Smith** showed cases of (1) progressive muscular dystrophy, (2) paroxysmal tachycardia, (3) a man who exhibited symptoms of a combination of locomotor ataxia and multiple neuritis.

These were discussed by Drs. **Little**, **Craig**, and **Moorhead**.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held Friday, November 15th, 1907,

Dr. **George Carpenter** in the chair.

Dr. **G. H. Lock** read a paper on a case of

RHEUMATIC HYPERPYREXIA

in a child of six, who a year previously had had an attack of chorea. On September 10th, 1907, she had left lobar pneumonia, which terminated by crisis on the fifth day; two days after the crisis the choreiform movements returned.

On September 20th there was pain in the left hip, and the temperature rose to 100 deg. F. Subsequently other joints became involved, and the case was a typical one of acute rheumatism with chorea. On the third day the temperature rose to 107 deg. F. In spite of treatment by ice pack and graduated bath, death occurred on the fifth day, the temperature just before death being 110 deg. F. The severe choreic movements ceased only with death.

Dr. **Eldon Pratt** read the notes of a case of (1) fractured lower jaw in a child of four. The child had been kicked by a horse, and the fracture was vertically through the symphysis. It was treated by a dental splint. Union was firm at the end of fifteen days, and a perfect result was obtained, there being complete absence of any deformity.

(2) Notes on a case of vaccinia. The patient was a baby who was vaccinated when six days old in four places on the left arm. Six days later all four places had taken well; ten days later there was extensive ulceration over the arm, measuring 3¾ inches by 4¼ inches, the surrounding skin was much inflamed, and there were pocks of auto-inoculation near the left axilla and over the right ribs. The whole of the body, face, and limbs was covered with a diffuse papular rash. The condition rapidly subsided under boracic fomentations.

Dr. **George Carpenter** showed a boy of 11, with a "Tuberculous Tumour of the Pons," verified by Calmette's ophthalmo-reaction. Subjective symptoms commenced in August; optic neuritis and ophthalmoplegia externa appeared the end of September. He was now leading a fatuous existence, and had continuous incontinence of urine and fæces. He could answer questions rationally, and called out if he wanted anything. Headache was now rarely complained of, sickness had disappeared, the knee jerks were absent, he lay curled up in bed, and although blind from choked discs was contented.

Dr. **Carpenter** was not in favour of trephining for the relief of optic neuritis; he thougnt the drawback of a hernia cerebri, the improbability of ameliorating the local condition, and the possibility of bringing the child back to even a temporary recognition of its unhappy state, contra-indicated any surgical interference.

Dr. **Poynton** showed a case of œdema persisting since birth. Child æt. two years, male. Swelling of the feet had been noticed since birth, varying in amount; eyelids had been swollen in the mornings; there was well marked swelling on the dorsum of each foot, with slight pitting on hard pressure. Urine normal quantity, faint trace of albumen, and a few degenerative cells with scattered leucocytes; no casts or crystals. He thought that there was some renal fault of congenital origin.

Dr. **G. A. Sutherland** showed a female child of seven months. The feet had been swollen since birth, the sole of each foot being tense and hard, while the dorsum was soft and pitted on pressure. Marked blueness of the foot followed exposure to cold. The child had suffered for some weeks from lichen urticatus, with very large wheals on the head. There was no evidence of renal or cardiac disease. The hands were not œdematous, but became blue on exposure to cold.

Mr. **Russell Howard** showed a case of precocious development of the obese type in a girl. He could find no evidence of any disease of the ductless glands, or the accessory genital organs.

Dr. **Porter Parkinson** showed a case of (1) facial paralysis in a girl, æt. 3½, with some weakness of the leg, apparently due to encephalitis. (2) A case of lymphadenoma affecting the cervical glands in a boy, æt. six.

Mr. **R. Warren** showed a case of congenital dislocation of the hip joint in a girl of 5 years. Skiagrams showed that the femur had a very small neck and no head.

Mr. **Hugh Lett** showed a case of acute arthritis of the hip joint in a boy of 11; treated by irrigation and drainage. The patient had recovered with perfect movement in the joint.

Dr. **Clutterbuck** showed a case of intention tremor in a child of 5½ years. Labour was tedious, and completed with instruments. No history or evidence of syphilis. The child never had convulsions. She is rather backward mentally, and did not walk until she was three years old. There was coarse intention tremor of the hands, and marked inco-ordination and spasticity of the lower limbs. The knee-jerks were increased, and Babinski's sign was present. No changes in the fundi.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held at Sheffield, November 15th, 1907.

The President, Dr. **E. O. Croft** (Leeds), in the Chair.

Mr. **R. Favell** (Sheffield) exhibited two specimens of "Fibro-myoma Uteri," one undergoing calcareous, the other cystic degeneration. (2) An ovarian cyst, in which axial rotation of the pedicle had occurred. (3) Syphilitic hypertrophic enlargement of the labia majora in a patient, æt. 28, who had one child nine years ago. There had been no abortions. She gave a history of a lump in the external genitals for the last eight years. Soon after her confinement, a year previously, she had noticed some small hard lumps about the anus which never quite disappeared. Five years ago one of these tumours was the size of a hen's egg, and within the last six months others had appeared. The largest growth, the size of a small cocoanut, was in the left labium majus. Both labia were excised, and microscopic examination showed a loosely-woven fibrous tissue structure, with inflammatory reaction, especially around the vessels.

Mr. **Archibald Cuff** (Sheffield) showed calculi removed per vaginam from the left ureter of a patient who suffered from symptoms of stone in the kidney. A radiograph located them 2 inches above the entrance of the ureter into the bladder.

Dr. **Miles H. Phillips** (Sheffield) exhibited the uterus containing a submucous fibroid undergoing sarcomatous change. It was removed by abdominal section from a nulliparous patient, æt. 50, in whom menorrhagia had been present for nine years. There had been inter-menstrual bleeding and an offensive purulent discharge for 14 months. On admission the temperature was 101, and small sloughs were detected in the vaginal discharge. The cervix uteri was patulous, and the uterus was the size of a four-months' pregnancy. Exploration of its cavity revealed a friable growth which microscopically proved to be sarcomatous. The cervix was therefore stitched, and removal of the uterus and appendages carried out by abdominal section. Five weeks after the operation the patient died suddenly from pulmonary embolism, and the autopsy revealed septic thrombi in the internal iliac veins and an embolus in a branch of the right pulmonary artery; there was no peritonitis. The microscopic sections demonstrated a mixed-cell sarcoma originating from the muscular fibres, submucous fibromyoma, and invading the uterine wall.

Dr. **Percival E. Barber** (Sheffield) mentioned the case of a woman, æt. 34, who had had one child three years ago. Two weeks after an abortion bleeding began, and was accompanied by a febrile condition. The uterus was enlarged and the cervix patulous. Suspecting chorion-epithelioma, a scraping removed by the blunt curette was examined microscopically, but did not confirm suspicion. As the patient was becoming progressively worse, abdominal section was performed, but her condition did not justify an attempt at the removal of the uterus being carried out. Recovery, however, gradually took place, and the patient became perfectly well.

Dr. **W. E. Fothergill** (Manchester) mentioned two cases illustrating the value of Schuchardt's paravaginal incision. In the case of a single woman, æt. 38, with a large submucous fibroid, the uterus extending to the umbilicus, abdominal section was contraindicated on account of an extremely offensive discharge in a debilitated patient. The removal of the tumour was rendered possible per vaginam by an incision into the left ischio-rectal fossa, and extending backwards to a point half an inch behind the anus. In the second instance, also in a single woman, with a very narrow vagina, hysterectomy for a myomatous uterus was performed after a preliminary incision.

Mr. **R. Favell** also reported four cases of ectopic gestation. *Case* I.—A woman, æt. 27, who had one child 12 months ago; had menstruated regularly 3/28 days. Her last period began a month ago, and continued for a week. It was followed by a severe peritoneal crisis. On admission there was marked tenderness in the right flank, and a soft swelling could be felt behind the uterus. Abdominal section performed forthwith revealed free blood in the peritoneal cavity, and clots in the pouch of Douglas. One inch from the uterine attachment of the right Fallopian tube there was a swelling the size of a filbert nut, on the posterior aspect of which a rent had occurred. The tube was removed, and recovery was uninterrupted. *Case* 2 was of a full-term ectopic gestation, in a woman, æt. 30, 10 years married, with one child nine years old. Menstruation was in abeyance from November, 1906, until July, 1907, when she had a red vaginal discharge for a week. At this time she felt movements in the abdomen. She had become progressively stouter, and thought herself pregnant, but as labour did not come on, she sought advice a fortnight since. The abdominal tumour resembled the full-term uterus, but no fœtal parts could be felt, and no heart-sounds or souffle heard. At the upper limit of the tumour there was something like a softened fœtal head. Bimanually the cervix was hard and closed, and the uterus lay between the tumour and the symphysis pubis. The sound passed 5 inches. Abdominal section showed the gestation sac to be adherent to the parietes and omentum, and to be intimately connected with the left appendage. The uterus lay in front and to the right. The sac and its contents were removed intact, and although there was considerable shock following the operation, the patient was making a good recovery. The specimen was being investigated. In the other two cases there was disease of the opposite appendage, which was also removed, and in one case the uterus was also removed, as the sac was intimately adherent to it.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Nov. 24th, 1907.

Treatment of Gastric Ulcer

At the ninth session of the Congrès de Médecine held last month in Paris, three questions were treated: Hemophilia, ulcer of the stomach, and exophthalmic goitre. M. Linossier read a paper on the treatment of gastric ulcer, of which the following is a summary:—

Dietetic Treatment.—Theoretically, absolute suppression of all gastric activity, complete rest of the organ until complete cicatrisation of the ulcer would be the ideal treatment, but in practice, the danger of inanition is an obstacle to this desideratum.

Was it not possible to introduce, otherwise than by the mouth, alimentary substances into the organism so as to realise rest of the stomach without the inconvenience and dangers of inanition? To meet this end four different methods have been tried; subcutaneous, peritoneal, jejunal, rectal.

As to the value of nutritive enemas, it is impossible to arrive at a formula applicable to every case. In certain subjects, absorption is almost nil, while in others, these enemas seem to almost suffice for the needs of the organism. However, the psychic action of this treatment must not be lost sight of; the patient is convinced he is nourished and for that reason supports inanition.

Where the suppression of all liquid or solid food, although momentarily, is considered impracticable, the diet allowed should fulfil four conditions; not to provoke any irritation of the gastric walls, that is to say, the food should be liquid or slightly thickened, neither too hot nor too cold; to sojourn as little time as possible in the stomach; to stimulate as little as possible the gastric secretion; to protect, if possible, the ulcer from the digestive action of the gastric juice.

Medical Treatment.—Absolute rest in bed and the ice bag to the epigastrium. Although its action on the hematemesis is doubtful, it is a good means of keeping the patient quiet. After a few days, the ice can be replaced by a simple warm compress, protected against evaporation and refrigeration by means of oil silk or some other impermeable tissue. The patient must be well covered in bed, and hot bottles placed to his feet, as any lowering of his temperature is very prejudicial.

If the subject is sufficiently vigorous, total suppression of solids or liquids by the mouth might be prescribed, and towards the second or third day subcutaneous injections of artificial serum might be given.

Nutritive enemas will be prescribed as soon as the patient can support them. Each morning an evacuating enema will be given first and after its operation, a nutritive enema, which can be repeated twice during the day.

Egg, one.
Dextrin, 2 dr.
Phosphate of soda, 15 gr.
Bicarb. of soda, 15 gr.
Laudanum, 6 drops.
Water, 10 oz.

If these enemas are well tolerated, they might be increased in nutritive value.

Eggs, 2 or 3.
Dextrin, 4 dr.
Bicarb. of soda, 15 gr.
Beef tea (without salt), 10 oz.

If well tolerated, this treatment might be continued a week, when a little sweetened water may be given by the mouth, and on the following day milk. The quantity of milk given the first day should not exceed ten ounces, when it may be gradually increased to a quart and a half. If the patient complains of burning in the stomach (due to a too free secretion of H.Cl.), the hyper-acidity might be corrected by a little bicarbonate of soda, but in such cases only. While undergoing this first period of nutritive régime, the stomach of the patient should be carefully examined by percussion and palpation so as to ascertain that it has not become distended for want of tone, and that the evacuation of the contents is not abnormally prolonged. In such a case the quantity of milk must be diminished, but its nutritive qualities may be increased by the addition of milk powder, lactose, cream, rice, tapioca, or casein. Where pain persists in spite of this more nutritious régime, bicarbonate of soda or subnitrate of bismuth might be prescribed in large doses. If no relief comes from this treatment, the question of operating might suggest itself (gastro-enterostomy).

Constipation is best treated by enemas of olive oil, and anemia by subcutaneous injections of cacodylate of soda.

Such is the treatment of a typical case of gastric ulcer, and if properly conducted, the symptoms disappear, but frequently the cure is only apparent and momentary, and the patient is always exposed to a relapse.

Treatment of Hæmoptysis.

The first thing to be done and before all other treatment is to inject 4 drachms of a solution of gelatine into the cellular tissue of the abdominal wall.

Gelatine, 2 dr.
Chloride of sodium, 1 dr.
Water, 1 pint.

The solution should be sterilised. The injection should be repeated each day or twice a day if necessary.

Internally:—

Ergotine (Bonjean), 1 dr.
Gallic acid, 10 gr.
Syrup of turpentine, 1 oz.
Water, 4 oz.

Chloride of calcium, 1 dr.
Ext. of opium, 1½ gr.
Syrup of peppermint, 1 oz.
Water, 4 oz.

A tablespoonful of these two mixtures to be given alternately every hour.

If the hæmoptysis does not yield to this treatment, an acid mixture might be tried.

Aromatic sulphuric acid, 4 dr.
Water, 1 quart.
A wineglassful every two hours.

Or,

Digitalis powder, } a a gr.
Hippo. powder, }
For one pill.

Five to six daily, until nausea sets in.

GERMANY.

Berlin, Nov. 24th, 1907.

At the Verein für Innere Medizin, Hr. E. Klebs discussed the subject of

Immunisation in Tuberculosis.

He said that in civilised lands the majority of the population had suffered at one time or other from tuberculosis, the traces of which were recognisable. Naegele's assumption that 90 per cent. had thus suffered was not far wrong. From the speaker's own investigations he would say that the percentage of people who had been attacked by the disease and had recovered more or less of themselves was 65. These recovered by self-immunisation, for self-recovery and immunisation were the same thing. But this self-healing was, in consequence of self-infection, very frail. The phthisical patient who expectorated tubercle bacilli up to his old age, and was therefore a danger to those around him, was himself immune, until he succumbed to a relapse. If these senile tuberculous patients had no cavities, they died of repeated catarrhs, which were not recognised as tuberculous. Such cases were extraordinarily frequent. Even in middle life such conditions were by no means unknown.

It might, perhaps, be objected that such a partial immunisation did not deserve its name; but it happened everywhere, and in all diseases; there was everywhere a partial and relative immunity. The histories of small-pox, and the plague, of cholera and diphtheria showed this.

Now arose the question that could only be settled experimentally: How did immunity arise in tuberculosis? It was undeniable that self-healing took place in a few cases, and our endeavour must be to bring about this result at pleasure. These experiments in immunisation could be carried out in two directions, either by procuring mitigated bacilli, as was done by Pasteur, and after him by Chauveau in the seventies, or by searching for immune bodies in tubercle cultures.

The speaker had become acquainted with two facts that struck out a more accurate way of reaching immunity. The first was that in the recovery of guinea-pigs from tuberculosis the active principle lay in the substances passing over in the glycerine extract of tubercle bacilli. He further found in his experiments with injection of tubercle bacilli, where the injections were successful, the wandering cell became active, and led the tubercle bacilli to the nearest lymph glands. In the blood, on the other hand, the tubercle bacilli were mostly quickly destroyed. In inhalation experiments he found that when tubercle bacilli reached the lungs in small quantity, the lungs soon got free of them, under normal circumstances, as the wandering cells took up the tubercle bacilli and without exception carried them to the bronchial glands. The tubercle "sozine" prepared from the glycerine extract of tubercle bacilli favoured this action, and might lead to recovery. After showing some tables relating to his experiments and preparations, the speaker said that we here saw a genetic connection between scrofula and tubercle. The scrofulous new growth was in the first place the result of hyperleucocytosis caused by tubercle bacilli products; the dead tubercle bacilli were found in large-celled lymphocytes in the scrofulous glands. This hyperleucocytosis was also demonstrable in the blood. Whilst the normal for guinea-pigs was 10,000 leucocytes, with 5·6 to 5·7 millions of erythrocytes, the number mounted in animals that had been treated with tubercle-sozine to 18,000 to 20,000.

Whence these tuberculophile wandering cells came was not clear. They were mostly thought to come from bone marrow, but his cases rather pointed to the spleen. It was a fact that these disturbances that were not wanting in human tuberculosis always began with swelling of the spleen, and belonged to the most typical form of pseudo- or true leucæmia. At any rate, they always led to splenomegaly. As a second organ the liver became diseased, so that properly all these cases were examples of the so-called Banti's disease—splenomegaly with cirrhosis of the liver. Death took place when the like process finally took place in the lungs. The speaker would trace back the whole group of lymphomata and lymphosarcomata to such latent tuberculosis. In these cases these tuberculophile wandering cells did not die, but lived on independently in the organs into which they had wandered. This new growth, therefore, resting on a pathological basis, was originally a natural process of cure which only did harm when it was in excess. Lymphomatosis and leucæmia stood near together genetically, and probably to be ranked with them was Hirschfeld's erythræmia with splenomegaly. Naturally other things might set up a similar process—for example, feeding with carcinoma.

This specific artificially induced leucocytosis had still another aim—it always reduced the temperature, for the reason, according to the speaker's opinion, that the tubercle bacilli that led to fever through their dissemination in the blood were conducted to the lymph glands and there taken up.

Investigations were in progress for the purpose of showing how far this inoculation would remove a fresh infection, or carry an existing one to recovery. Of course, the usual bactericide substances would still be employed in all cases of serious tuberculous infection.

AUSTRIA.

Vienna, Nov. 24th, 1907.

Multiple Sclerosis and Urinary Trouble.

Hochwart presented a patient, æt. 16, to the "Gesellschaft für Innere Medicin" with a persistent desire to micturate, evidently due to a nervous origin. The bulbar shaking in the extremities and eyes was unusually slight. The urine was normal. A few months before this examination the patient was troubled with retention, followed by a dribbling, uncomfortable condition. Then commenced nystagmus, increased patellar tendon reflex, more sensitive in the left than the right, slight ataxia in the left extremity, and hyper-hemi-algesia in the left side. All the phenomena of multiple sclerosis were present.

Optic Aphasia.

Stejskal next exhibited a case from the Second Medical Clinic which he diagnosed as optic aphasia after a severe attack of meningitis. When received into hospital the patient was stupid or benumbed mentally, neck stiff, pupillary reaction in left eye quite gone, but the right responded slightly. The abdomen was distended; taches cérébrales and Kernig's symptom—*i.e.*, loss of contraction in the lower extremities by passive movement. There was also bradycardia = 64, with elevated temperature, confirming the symptoms of meningitis. Later bilateral neuritis optica set in, with right hemi-anopsia, right facial paresis, with a slight deviation of the tongue towards the right when put out of the mouth. Three weeks later the patient improved in every one of the symptoms, but a pronounced sensorial aphasia set in, which also improved after a time. Repeated aspirations in the lumbar region were performed, giving on every occasion a hæmorrhagic fluid rich in leucocytes and rods with capsules which gave a negative result with the Gram method. Prof. Ghon said these bacilli belonged to the capsule group, and in shape resembled Friedländer's bacilli. Many cultivations in opposition to expectoration proved it invulnerable to this mode of treatment, as the capsuled bacilli are usually easily cultivated.

Hypoplasia of the Aortic System.

Hans Politzer brought in a case from the Second Clinic with a defective aortic system and hypertrophy, with dilatation of the heart. The apex beat was in the fifth intercostal space two finger-breadths outside the mammillary line, with every sign of hypertrophy and dilatation. Auscultation gave a systolic murmur loudest over the pulmonalis, where a second pulmonary sound was heard. The heart's rhythm was regular, pulse 88 to 92, no pulsation in the cervical veins, but the carotid was small, with a very weak pulse. There was no sub-clavian or jugular pulse even when the diaphragm was highly elevated. The radial and crural arteries were very small, while no pulsation could be found in the dorsalis pedis.

From this he concluded there was hypoplasia of the aortic system, with hypertrophy and dilatation of the cardiac. The patient was pale, with 6.5 millions of erythrocytes and 16.6 per cent. of hæmoglobin.

Cirrhose Bronzee.

Falta exhibited a case of cirrhosis from the First Clinic. The case was received into hospital with alcoholic polyneuritis, enlargement of liver and spleen, ascites, and a mulatto bronzing of the skin over the whole body. When the neuritis subsided the bronzing of the skin became much less, showing a direct connection with the neuritis.

Cirrhose bronzée, cirrhose hypertrophique pigmentaire, or cirrhose avec Mélanodermie, are all characteristic of alcoholic excess, which seems to produce a hæmo-chromatic substance in the large organs of the body, lymphatic glands, skin, lungs, bone, marrow, etc. This condition seems to have a close affinity to the diabète bronzé, Cachexie bronzée, dans le diabète sucré, and may be the origin of the hæmo-chromatosis. This substance is found as fine granules in the basal cells of the Malpighian layer.

Cardiac Insufficiency.

Eppinger gave a description of his experiments on animals to test the efficacy of under-feeding or hungering would have on a hypertrophic heart. His results clearly show that after five days the animal is unable to bear insufficiency or the sinking blood pressure, but if intravenous injections of dextrose, levulose and glycogen be given, the pressure rises and the animal is quickly restored.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Women Graduates and the University Franchise.—A further stage in the action brought by some of the women graduates against the Universities of Edinburgh and St. Andrews was reached on Saturday, the 16th, when the judgment of the Lord Ordinary was upheld by the Extra Division of the Court of Session. The action was raised in order to compel the University to send voting papers to the female graduates, and for declarator that women are entitled to vote at the election of a member of Parliament for the Universities. The decision of the Lord Ordinary was against the women graduates, and against this decision they re-claimed. Lord Maclaren, in giving the judgment, said that it was a principle of the unwritten Constitutional law of the country that men only were entitled to vote. Ambiguous expressions in Acts of Parliament must be construed in the light of Constitutional principles. If it was intended to subvert a Constitutional principle, it must be done by the Act in the plainest language. At the time the Act was framed it was not necessary expressly to exclude women, because women could not then be legally on the register. The argument was that a franchise originally conferred on graduates who were necessarily men had been extended to women, not by a direct enactment, but by the indirect effect of an Act of Parliament which was concerned only with academic functions, and in the interests of the higher education of women authorised their admission to a degree. It was difficult to conceive that the Legislature should have devolved the power of conferring the franchise, a power which it had always kept in its own hands. The Lord Ordinary's judgment was therefore affirmed, and the reclaiming note refused.

Glasgow Medical Officer and the Plague.—Dr. Chalmers states that towards the middle of October a case of plague was admitted to hospital. The boy is now free from infection, and is progressing favourably. When this case occurred it was also established that a death in August last had been due to a like cause. Both were removed from the same district of the city. According to Article 7 of the Paris Convention, the occurrence of such an isolated case does not constitute an infected area, and the measures prescribed by the Convention for infectious areas are not put into operation. Article 9 provides that any area which may have been declared infected ceases to be so five days after the death or isolation of the last case in hospital.

Tuberculosis and the Glasgow Milk Supply.—Dr. Chalmers states that in consequence of the detection of tubercle bacilli in samples of milk taken at a railway station, the public authorities of the district whence the milk came arranged to inspect all the dairy animals. This led to the discovery of two cows with tuberculous udders. As a further result of the inquiry, Dr. Buchanan reports two additional infected samples of cream from another county, and inquiry at the farms there has revealed the existence of cows with udder disease. In 77 samples of cream, three have been found capable of transmitting tuberculosis. The question cannot remain long unsettled as to the course a consuming authority may adopt when tuberculous milk is on sale within its area, along with milk produced at its own byres under conditions which render tuberculosis improbable. It might be desirable to secure Parliamentary power to prohibit the sale within their own boundary of milk from districts where repeated evidence of tuberculosis among milch cows had been obtained.

WOODILEE ASYLUM: ANNUAL REPORT.—During the year there were 1,271 patients under treatment; 177 males and 159 females were admitted, and 75 men and 80 women were discharged. The deaths numbered 123 —males 58, women 65. The rise in the admission rate was 71 as compared with last year; this is due to the reception of imbeciles from the Larbert and other institutions, and to the admission of senile cases. On this account the recovery rate is also unusually low—27.79 per cent. as compared with 37.9 in the preceding year. A system of electric baths has been installed in the men's asylum.

BELFAST.

THE IRISH UNIVERSITY PROBLEM.—Mr. Birrell in a speech delivered at Belfast during the past week added a little to our knowledge of his proposed solution of the Irish University question. In the first place he told his audience that all the surmises which had recently appeared in the newspapers was "all unauthorised and almost wholly false." He then added that "we cannot expect to attain what we want without a considerable amount of unanimity," and he rejoiced to say he was receiving a "considerable amount of support even from quarters where he did not expect it." He told his audience that "the question was a very difficult one," and that rightly or wrongly he believed he had "the opinion of the best people in Ireland, irrespective of party, behind him." He then added: "We know that seats of learning in these days must be entirely unsectarian. They must be free, they must be on their emoluments, in their fellowships, in everything pertaining to them free and open to all the world, irrespective of religious opinion." The Bryce scheme is dead. A *bonâ fide* Catholic University scheme is apparently equally dead—though of that there was never any doubt, and everything points towards the fulfilment of the recommendations of the Robertson Commission, as we have already pointed out in our last issue. Whether this scheme is to be modified by the establishment of a University in Belfast will probably not be definitely known for some time, but in view of Mr. Birrell's statement regarding the accuracy of newspapers, a Belfast independent University does not seem to be likely. But for that statement, there are many indications that such a scheme is in the air.

THE REGISTRAR-GENERAL AND REGISTRATION DISTRICTS.—At a meeting of the Lisburn Board of Guardians last week an interesting discussion took place on the reading of a letter from the Registrar-General, refusing to constitute the Purdysburn Infectious Diseases Hospital into a separate registration district, as he had been requested to do. He replied that in no case, so far as he was aware, had any public institution in the United Kingdom been made a separate district for registration purposes, but, as Dr. Orr pointed out, there is probably no other instance in the United Kingdom of a large city "dumping the physical and mental wreckage of the city" into an unoffending country district. It must be remembered that not only is the Infectious Diseases Hospital for Belfast situated at Purdysburn, but also the District Asylum. It certainly seems rather hard on the registrar for the district that all the extra registration work which this involves should fall upon his shoulders; work which really belongs to the City of Belfast, and not to the Lurgan Union.

PROPOSED INEBRIATE HOME FOR THE NORTH OF IRELAND.—An informal meeting was held last week in the Medical Institute, Belfast, to discuss the proposal to open an inebriate reformatory somewhere in the North, the suggested site being the disused County Gaol at Downpatrick. The meeting was convened by Dr. Norman Barnett, the honorary secretary of the local branch of the British Medical Temperance Association, and was presided over by Dr. Calwell, the president of the same body, but the attendance was not limited to medical men, a number of clergymen of all denominations and several laymen being present. There is no such reformatory in Ulster, or indeed north of Dublin, and the meeting was generally agreed that it was quite time to start one, on the broadest possible foundations, and a committee was formed with this object in view.

HEALTH OF SCHOOL CHILDREN.—At a meeting of the Public Health Committee held last week a report on the International Congress of School Hygiene was presented by Dr. Henry O'Neill and another member, and a series of recommendations were made. These, if adopted, would revolutionise education in the city, for they advise the Corporation to take over the control of secular education in both primary and secondary schools, providing and maintaining new primary schools where necessary, and to appoint a special medical officer, under the Medical Officer of Health, to supervise school hygiene in the city. Dr. O'Neill is a barrister as well as a medical man, so he has presumably considered the legal aspects of his recommendations, but they strike one as fairly courageous and sweeping!

TUBERCULOSIS.—Belfast is revelling in an orgy of popular medicine at present, the Tuberculosis Exhibition being in full swing. It was opened on Friday, 22nd, with an address by Sir Douglas Powell, who created a little breeze in medical circles by expressing his disapproval of compulsory notification to which the Ulster Medical Society, like most other medical bodies in Ireland, is committed. It is said that we may comfort ourselves with the knowledge that another London consultant placed our Dublin colleagues in a similar predicament by pronouncing tuberculosis non-contagious. As far as one can judge from the opening days, the exhibition promises to be a great success, and the programme of lectures by medical men is an excellent one. The Corporation proposed a little time ago to open a dispensary for the out-patient treatment of tuberculosis, but the Local Government Board have refused to sanction the scheme, saying that there is no power under any Act of Parliament for such a expenditure.

LETTERS TO THE EDITOR.

THE LATEST PHASE OF THE TRYPSIN TREATMENT OF CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—My attention has been drawn to a book published by Dr. C. W. Saleeby entitled "The Conquest of Cancer."

I feel bound to take some notice of this publication by reason of the fact that certain misrepresentations distributed throughout the book have been made in regard to my introduction of the method of treatment of inoperable cancer by trypsin, and the considerations which led me to it.

This is a book which purports to inform the public respecting the views now held by the scientific workers of the profession as to the present position of the cancer question, and the method adopted by the author of carrying out this design is that of abusing everyone who does not happen to agree with himself or Dr. Beard.

I do not deem it necessary to re-discuss the question of priority so far as the introduction of the trypsin treatment of cancer is concerned, inasmuch as my claims have been recognised by independent observers in the scientific Press of this country (vide *Nature*, January 10th, 1907).

But Dr. Saleeby would have his readers believe that Dr. Beard first suggested the treatment, and that I only employed or advocated it. After referring to a paper read by the latter in Edinburgh on December 13th, 1904, an abstract of which was printed in the *Lancet* of February 4th, 1905, he goes on to say:—"Only a few weeks after Dr. Beard's lecture, Dr. Shaw-Mackenzie began the hypodermic use of trypsin in cancer, and to him undoubtedly must be awarded the credit of being the first physician to employ the new treatment. . . . My purpose is to illustrate the conditions under which discoveries are made, and I will here quote from a private letter of Dr. Beard to myself:—'At once, December 8th, 1904, I got all my critical period preparations . . . and saw at once that I had neglected to lay stress as a character of the critical period on the commencing functional activities of the pancreas gland. So the problem was solved so far. The other thing is a later story. At once I saw there must be an antithesis of ferments, but was not aware whether any ferment had been described in the cancers. . . . January 18th, 1905. . . . Then it was you might have heard my heart thump. All was exactly as I had foreseen. . . .' This letter was not sent for publication, but I have taken the liberty of putting it on record for its personal and general interest."

It was on December 8th, 1904, as published by me in the *Lancet*, February 11th, 1905, I commenced investigations into the action of pancreatic and other ferments on glycogen. The considerations which led me to this were known to many, and published in a pamphlet of mine in October, 1904, in the *British Medical Journal*, January 7th, 1905, and the *Lancet*, January 14th, 1905; but I will here take the liberty of quoting from a letter of Dr. Beard to myself dated December 7th, 1905:—"When you get this letter on December 8th, it is a year exactly since you and I independently arrived at the trypsin idea. . . ."

The strenuousness of the efforts displayed by Dr. Saleeby in the lay Press, no less than in his book on behalf of the claim of another, must clearly demonstrate to any impartial person the weakness of his cause. If anything more was required it is the attempt to submit my work to destructive criticism. It is repeatedly reiterated that trypsin has no action on glycogen. "There is no ferment," he says, "which affects both proteids and carbohydrates, such as glycogen." This is simply begging the question. Observers of old regarded glycogen as starch in proteid combination, and the purest glycogen obtainable still contains nitrogen. Moreover, the action of the proteolytic ferment rather than the amylolytic was and is supported by the fact recently and independently testified to that glycogen exists in the living tissues as proteid-glycogen. Dr. Saleeby mentions Dr. Odier's work. He does not mention that in growths treated with a mixture of pancreas, liver and muscle extracts, coincident with atrophy of cells, histological examination has shown them to be deprived of glycogen. Drs. Saleeby and Beard attribute any action on glycogen to the leucocytes, forgetful that the digestive properties of these are attributed to a proteolytic ferment apparently identical with trypsin. This additional aid of the leucocytes and increase has long been recognised, and found expression in hypodermic injections of chian turpentine introduced by Col. T. Ligertwood, C.B., M.D., and myself three years ago. Most suggestive of the action on glycogen at the present time is that the pancreas produces an "activator substance for a glycolitic enzyme contained in other tissues." Whatever the explanation, it is obvious the glycogenic nutrition of cancer may be interfered with, whatever the precise nature of the cell proliferation, be it epithelial or "trophoblastic."

Again, while my theory of cancer by analogy with diabetes is noted, no mention is made of the clinical fact of alternation of diabetes and cancer in different members of the same family, which directly led me to the inference that if, as is well known in certain cases, diabetes is a pancreatic disease with defective ferment action, so also might carcinoma be. He notes my suggestion of premature ageing of the pancreas, only to reject it, and to advance on his own account a shortage of trypsin from "whatever cause." In this respect readers of my work will know that, in referring to the age incidence of cancer, I suggested also congenital imperfections, and in referring to cases of spontaneous cure I suggested the removal of inhibitory—*e.g.*, mental, nervous, trophic or chemical causes temporarily interfering with either the general or local supply of the proteolytic ferments.

I pass on to chapters on the preparations of the ferments and the details of treatment. Is there anything here which is not known or indicated in my book? Injections of trypsin were first prepared by Mr. F. W. Gamble, for me. Of early cases treated, two at the present time are apparently in good general health, 2½ and 2 years, whether it is due to treatment or not. The injections were sent to Dr. Beard, at my request, by Messrs. Allen and Hanburys for the purposes of Dr. Beard's experiments on mice, and full information and composition were given by me. As for technique and details of treatment—"hypodermal, oral, and local"—these were fully published by me (*a*), and Dr. Saleeby's recommendations are, so far as I can see, for the most part adopted from my work without acknowledgment. He differs essentially in the importance he attaches to amylopsin and in the additional recommendation of amylopsin injections.

I imagine that most persons will find the most effective commentary upon this and upon questions of the strength of trypsin solutions discussed by Dr. Saleeby, in a paper by Dr. Hald, of Copenhagen, published in the *Lancet*, November 16th, 1907, (*b*) in which the author shows that the so-called solutions of amylopsin actually contain an abundance of proteolytic ferment, and in which paper also the author independently establishes the potency of British tryptic preparations.

Yours faithfully,
J. A. Shaw-Mackenzie, M.D.Lond.

[We have already accepted the evidence in favour of Dr. Shaw-Mackenzie's priority of claim to the trypsin treatment of cancer as established. Dr. Saleeby has not favoured us with a copy of his book for review.—Ed. M. P. and C.]

DISEASES OF TWINS.

To the Editor of The Medical Press and Circular.

Sir,—As father of twin boys I am able to add a small contribution to the inquiry which Mr. J. Lionel Tayler makes in your columns. My boys have just entered upon their nineteenth year. For the first twelve years of their lives their physical characteristics as to height, weight, and measurements remained closely alike; but they were always markedly different in feature and in mental characteristics. They have since varied in physical development, and have shown more marked mental and intellectual differences. They are well formed, uncommonly good-looking boys, but not very powerful. Their permanent teeth are without blemish. Their temporary sets were of very good quality. The firstborn seems to have stopped growing at 5ft. 6in., and has the mental qualities of a superior man of business; the second born, still apparently growing at about the same stature as his brother, is mentally up to the level of an average "scholarship" boy at a public school, and is thinking (somewhat to my discomfort), in the present deplorable position of the profession, of being a doctor. At four years of age they had influenza together, and with the rest of the household. At fifteen, at a public school, they both became affected with the mild variety of purulent ophthalmia, which sometimes becomes epidemic in schools. At sixteen, at a public school, they had measles, one a fortnight after the other, and, later, German measles. Later again they had whooping cough at the same interval. This is their complete record of disease.

Yours, etc.,
Paterfamilias Medicus.

November 23rd, 1907.

A ROYAL COMMISSION ON QUACKERY.

To the Editor of The Medical Press and Circular.

Sir,—You ask for outspoken views on this most important and practical of professional topics. Here are mine. I fully believe in the practicability and hopefulness of a Royal Commission as explained during late years in your correspondence and editorial columns, and I agree as to the flimsiness of the objections to it, provided always that the profession will

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(*a*) "The Nature and Treatment of Cancer" (Fourth Edition). By J. A Shaw-Mackenzie, M.D.Lond. London: Baillière, Tindall & Cox.

(*b*) Comparative Researches on the Tryptic Strength of Different Trypsin Preparations, and on Their Action on the Human Body." By P. Tetens Hald, M.D.

unite to carry the thing through. I view as either hypocrisy or twaddle the suggestion that the profession ought not to defend the simple public, and at the same time themselves, against the injuries of quackery, because the sole part of the profession is to succour the suffering and to work at science. This view has been put forth by members of the British Medical Association. The profession is the most altruistic existing, and its unselfishness would not be lessened if it boasted of as much consideration from the State as is accorded to veterinary surgeons and solicitors. The profession has always included in its ranks great numbers of men devoted to science; and through their discoveries and the work of medical men in promoting national sanitation, a great part of their sources of income has been done away with. This renders the obligation of the State to them all the greater. General practitioners, the bulk of the profession, are largely prevented from joining in scientific work under present conditions. Many of them are too badly off and dispirited, whilst those practising among the poorer classes are perforce dragged down to the intellectual level of their customers. The average general practitioner rarely has a chance of making a diagnosis in a case worth observation. The patient, fortified by a study of quack literature, makes his own diagnosis. He has headache, rheumatism, or "liver," as the case may be, and comes to the practitioner for "something to do him good"—something better than the quack nostrums with which he has been dosing himself. The practitioner knows that if he attempts to make a scientific diagnosis when this is necessary, he will not, in the majority of instances, be able to get any adequate payment for his trouble, even in the rare cases in which the patient will submit. So cases of incipient malignant disease and of all sorts of organic pathological activity go on from bad to worse, with no other treatment than useless or harmful drugging. My final view (for the present) is that if the coarser kinds of fraudulent quackery which appeal to the poor and ignorant were put an end to, not only would the mass of preventable human misery be at once largely diminished, but the general practitioner would be placed in a position in which he could act truly as a professional man, instead of as a tradesman, and his earnings would be increased to a degree raising him at least to a bit above the often degrading condition of hopeless shabby gentility in which he is at present forced frequently to remain.

I am, etc.,
An Obscure Practitioner.
November 21st, 1907.

WHY LET SCARLET FEVER SPREAD?

To the Editor of The Medical Press and Circular.

Sir,—I am not surprised to see it stated in the Press that London suffers from an epidemic of scarlet fever. It does not take the right way to prevent it—viz., to bring the earliest cases under medical inspection and care. This can be done by means of the Guardians of the Poor freely offering "medical relief" to all sick children whose parents are unable to pay for a doctor. Parents cannot tell whether a child's symptoms are those of scarlet fever or not, and they will not, under present circumstances, call in the Poor-law doctor if they can possibly help it, even though they cannot pay for one themselves. If they do apply to the Guardians, too often they are worried to repay the cost of medical relief, or made to come, like suppliants, before the board or the committee. They are treated like "paupers." A Medical Officer of Health once told me that "the poor did not mind having scarlet fever in their homes, but they did mind having the Poor-law doctor." This was not dislike of the Poor-law doctor, who was a kind and popular man, but they objected to the degradation and disagreeables connected with the Poor-law as it is administered by the Guardians and relieving officers. Now the receipt of medical relief does not disenfranchise, and the sooner the Guardians make it understood that those unable to pay for a doctor can have this help without difficulty or degradation, the better for the public health.

Of course the children have a legal right to medical relief, but Guardians can, and I fear often do, practically deprive them of it by discouraging applications in various ways. This, again, is partly due to the old-fashioned political economy, and to the Local Government Board inspectors, who think more about the diminution of "pauperism" than of the diminution of disease and death-rate. If the Local Government Board would issue a circular as to medical relief on the same excellent lines as the recent one as to midwives, much good would be done. Many of the poor, and many also of the Guardians, do not understand there is a legal right, and many of the poor do not know how practically to obtain it. The circular would be useful to all parties.

Yours, etc.,
J. Theodore Dodd, M.A.
Oxford, November 18th, 1907.

OBITUARY.

ROBERT J. PATON, M.D., C.M.Edin.

We regret to record the death of Dr. Robert John Paton, who died on November 16th from blood-poisoning, resulting on a slight scratch caused whilst conducting an operation. Dr. Paton, who was 45 years of age, and honorary surgeon to the Newport and County Hospital, five weeks ago, whilst performing an operation for appendicitis on a patient at the hospital, pricked his hand. Inoclation was succeeded by blood-poisoning. Dr. Paton was born in India, his father being Military Chaplain to the 72nd Highlanders. He received his early education at Dumfries, and subsequently at the Edinburgh University. For some time he was medical officer at the Crighton Lunatic Asylum, Dumfries, but about 16 years ago he went into practice at Newport. He obtained his M.B. at Edinburgh in 1886, and M.D. Edinburgh in 1899. Shortly after coming to Newport he joined the 2nd V.B. South Wales Borderers, and at the time of his death was surgeon-major of the battalion. He also took an active part in ambulance work, and was once tutor of the local railwaymen, and some of the Volunteer Ambulance Corps he trained saw active service in the South African war. His principal work at Newport, however, was as hon. surgeon to the Newport Hospital. He was also medical officer for the St. Woollos district of the Newport Union. He leaves a widow and one daughter.

SPECIAL ARTICLES.

ROYAL COLLEGE OF SURGEONS OF ENGLAND—ANNUAL MEETING OF FELLOWS AND MEMBERS.

The twenty-third annual meeting of fellows and members which took place at the Royal College of Surgeons on Thursday last was the best attended meeting for many years, nineteen fellows and 69 members being present. This was doubtless due to the fact that since the last annual meeting both the Society of Members and the Council of the College had been received at the Privy Council by the Lord President on the question of direct representation of members on the college council, the society having previously presented a memorial on the subject to the Prime Minister. The President of the College, Mr. Henry Morris, presided at the meeting, and opened the proceedings with a statement regarding the principal items included in the report of the council, which was laid before the meeting.

The President said that, with regard to the admission of women to the college diplomas, the council had passed a resolution in favour of such admission, and that if the Royal College of Physicians were favourable to the scheme a vote would then be taken of the fellows and members of the college. The council had decided that it was not desirable for the college to grant a Diploma in Tropical Medicine, but in order to give a *cachet* to successful students, they had decided to appoint assessors to be empowered to endorse the certificates in tropical medicine gained by the holders of the college's diplomas. With regard to the munificent gift of Mr. and Mrs. Bischoffsheim of £40,000 to the Imperial Cancer Research Fund, to celebrate the event of their golden wedding, the President made the interesting statement that, if happily the cancer research came to a successful termination, the interest on this sum would still be available for research into other diseases. As regards the council declining to take any action in the question of the representation of members on the college council, the President assured the meeting that the council was not actuated by any hostility or opposition to the members, but by the feeling that the suggested innovation was not in the nature of a desirable reform.

The resolutions, which were included in the last issue of the Medical Press and Circular, were all carried unanimously. Mr. F. W. Collingwood's resolution regarding the recognition of members of the college for becoming candidates for hospital appointments was seconded by Mr. H. Elliot-Blake; Mr. Joseph Smith's resolution re-affirming the desirability of admitting members to direct representation on the council was seconded by Mr. Brindley James, and a long debate followed on the question. Dr. W. G. Dickinson's resolution, in which he expressed regret that the report did not contain the reply of the Lord President of the Privy Council to the deputation of members of the college council, was seconded by Mr. S. C. Lawrence. Dr. Dickinson suggested that the advice given on behalf of the Government was that the council should obtain a new Charter, and that the action with reference to the admission of women to the examinations of the college was with the object of evading the necessity of getting a new Charter, because if a new Charter were granted for the admission of women to the examinations, it would have to include the admission of members to the council. The two resolutions standing in Mr. H. Elliot-Blake's name suggesting that the college and its work should join with the University of London so as to form an Imperial University of London, and that a hood should be added to the gowns worn by fellows and members, were seconded by Mr. Brindley James.

A vote of thanks to the President for presiding at the meeting concluded the proceedings.

MEDICAL NEWS IN BRIEF

Royal Army Medical Corps.

Captain H. R. Bateman has been appointed for special duty at the Royal Army Medical College.—Major S. F. St. D. Green has been appointed to the medical charge of the Louise Margaret Hospital for Women and Children, Aldershot.—Lieut. H. E. Gotelee, who has been doing duty at the Cambridge Hospital, has left Aldershot for Ceylon.—Capt. S. G. Butler, surgeon-in-charge of the Cambridge Hospital, Aldershot, has been ordered to embark for India. The November issue of the *Journal of the Royal Army Medical Corps* contains an important article by Surgeon-Lieut. E. L. Moss, who states that the rough flannel shirt issued to soldiers is responsible for some affections of the skin. He says: "As medical officer to the 2nd Battalion Royal Welsh Fusiliers, I have been greatly impressed by the number of men temporarily inefficient and requiring admission to hospital on account of boils and pustular skin infections, the result of scratching or chafing prickly heat. I have strong reasons for believing that the regulation flannel shirt is largely responsible for the condition."

Battersea "Brown Dog" Memorial

Ten students from Middlesex and University College Hospitals were charged on November 21st at the South-Western Police Court with causing wilful damage to the "Brown Dog" memorial at Latchmere Recreation Ground, Battersea, and after being sharply reprimanded and warned by Mr. Paul Taylor, they were fined £5 each. The "Brown Dog" statue was presented to Battersea by the International Anti-Vivisection Council, and was unveiled by the Mayor of Battersea in 1906. The inscription on it is in these terms:—"In memory of the brown terrier dog done to death in the laboratories of University College in February, after having endured vivisection extending over more than two months, and having been handed over from one vivisector to another till death came to his release. Also in memory of the 232 dogs vivisected in the same place during the year 1902." The dog is seated above a drinking fountain, at the base of which are the words: "Men and Women of England! How long shall these things be?" Mr. Paul Taylor said the erection of the momerial was perfectly legitimate, and the defendants should remember that there was another side to the question which they regarded as personal to themselves. He could not regard anything as more serious than the assembling of 500 students, for such conduct was calculated to lead to a public riot. He warned defendants if such conduct was repeated the offending persons would go to prison for two months without the option of a fine.

Assault on a Medical Man.

Mr. E. C. Hughes, of Guy's Hospital, was the subject of a serious assault in Soho on November 22nd. His assailant was a smartly dressed young woman, who went up to him as he left a hospital in Dean Street. She was carrying an innocent-looking brown paper parcel. There was an altercation between the two, which was cut short by Mr. Hughes saying, "If you follow, I shall give you in charge." Thereupon the woman struck him a blow on the side of the head with the parcel, which contained a heavy iron hammer. Mr. Hughes reeled and blood flowed from his head; he was only saved from falling by an onlooker. The woman was arrested and taken to Marlborough Street Police Station. Mr. Hughes went in a cab to Guy's Hospital, where it was stated last night he was suffering from a severe scalp wound.

Poor Law Medical Officers and the Supply of Expensive Medicines.

Recently, in approving the appointment of a District Medical Officer in the St. Germans Union, the Local Government Board informed the Guardians that they were of opinion that it was desirable that expensive medicines should be supplied to the sick poor at the cost of Boards of Guardians, and not at that of the Medical Officer, and requested the Guardians to take this opportunity of considering the matter with a view to the adoption of such an agreement. The Guardians decided to reply to the effect that it was not their custom to do as suggested. They had confidence in their medical officers to give the best medicines where needed, and that if the Local Government Board insisted on their suggestion being carried out in this case they would have to consider the position of the whole of the medical officers. So far no complaints had been received.

The Asylums Board and Bacteriology.

The Local Government Board having expressed their willingness to assent to a proposal to erect bacteriological and anti-toxin laboratories at Belmont, and the anti-toxin stables recently erected there being in working order, the Hospitals Committee of the Metropolitan Asylums Board have now decided to recommend the Board to appoint Dr. C. E. Cartwright Wood as bacteriologist at their establishment at a salary of £600 per annum, with an assistant at a salary of £300 per annum.

Trinity College, Dublin

The following candidates have passed the Final Medical Examination (Part II.), Michaelmas Term, 1907:—Surgery: George F. Graham (Passed on High Marks), Robert A. Askins, Wilfred J. Dunn, Julian B. Jones, Bethel A. H. Solomons, Thomas P. S. Eves, Henry D. Woodroffe, Francis O'B. Kennedy, James D. K. Roche, Wilfred L. Hogan, Henry J. Keane, Archibald L. Robinson, James R. Yourell, Joseph H. Elliott, James G. M. Moloney.

Society of Apothecaries of London.

The following candidates having passed the usual examinations, have received the L.S.A. Diploma of the Society entitling them to practise Medicine, Surgery and Midwifery:—M. F. Emrys-Jones B. S. Matthews, J. F. McQueen, G. H. Rodolph, and A. L. Walters.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

***Specially compiled for* The Medical Press and Circular.**

RECENT PATHOLOGICAL LITERATURE.

Toxicity of Therapeutic Sera.—Besredka points out that most therapeutic anti-sera possess (*Annales de L'Instit. Pasteur.*, No. 10, 1907), in addition to their anti-toxic properties, a certain amount of toxicity, which may show itself by the occasional manifestation of unpleasant symptoms following the therapeutic application of these sera. He has been able to estimate the degree of this toxicity by subdural injections of the sera into healthy guinea-pigs, and has been able to demonstrate certain facts thereby. The more important are as follows:—(1) The sera of horses living under similar conditions are of the same degree of toxicity; individual differences are rare and of little importance; (2) the variable toxicity of sera appears to depend partly on their age and partly on their origin; (3) all sera are very toxic on the day of the bleeding, but they lose their toxicity gradually in keeping. No therapeutic serum, however, should be used within two months of the date of bleeding. (4) Any serum which produces toxic symptoms in guinea-pigs in doses of 1-16 to 1-20 c.c. should be regarded as too toxic for use. M.

Immunisation Against Inoculated Cancer.—Bridré (*Annal. de L'Instit. Pasteur.*, No. 10, Oct. 25th, 1907) has carried out experiments with the object of establishing, if possible, a condition of immunity or increased resistance in mice to inoculable tumours. As a subject for experiment he chose a tumour of an adeno-carcinomatous type, which gave from 30 to 40 per cent. of successful results when injected subcutaneously He found, in the first place, that mice which failed to develop the tumour on a first inoculation very often developed it on a second occasion, and did not appear to have acquired any degree of immunity from the first injection. Those, however, who received two inoculations without developing a tumour remained immune as a rule when subsequent injections were given. Injections of fresh cancerous tissue were found in all cases to be more valuable than similar injections of desiccated cancerous material. It was found, however, that injection of normal tissues of a mouse also conferred a heightened resistance, and from this he concluded that the immunity could not be specific. The increase in resistance in all cases was proportional to the amount of tissue injected. M.

Surra in Indo-China.—Schein has studied exhaustively the diseases caused by trypanosomes in cattle in Indo-China, and to which the general term of surra is applied (*Annales de L'Institut. Pasteur*, September, 1907). He has come to the conclusion that although marked variations are noted in the course of various epidemics, still all the epidemics are due to the same trypanosome. The variations he attributes to what he terms the genealogy of the particular parasite in any case. He finds also that the buffalo is not protected after a single attack of surra, and that it can in many cases be the carrier of virulent parasites without itself showing any symptoms. Infected cattle, moreover, may be found outside the area of the epidemic regions. As aids to the extermination of the disease he recommends drainage and clearing of the country, filling up of stagnant pools, careful choice of pasture lands, careful segregation of diseased animals, and occasional systematic examination of healthy animals. M.

Staphylococcal Vaccines in the Treatment of Furunculosis.—Hartwell and Lee (*Boston Med and Surg. Journal*, October 17th, 1907) report the result of their observations on 100 cases of staphylococcal infections treated by Wright's methods. They have found that it is unnecessary in such cases to make use of a vaccine prepared from the actual organism that is causing the individual lesion, but that a stock vaccine of any staphylococcus aureus will do. In their earlier work the opsonic index was taken regularly, but later they found that equally good results could be obtained without the index by giving routine doses every four days of from 300,000,000 to 600,000,000 micro-organisms. The inoculations are made subcutaneously and at a fresh site on each occasion. They summarise their conclusions as follows:—(1) The vaccine treatment is the most effectual of all treatments for boils and carbuncles; (2) although this treatment does not prevent recurrence, cases of chronic furunculosis can be absolutely controlled by occasional inoculations; (3) the determination of the opsonic index is quite unnecessary, and the treatment can be carried out without special technical training. M.

Pain and Blood-Pressure.—Auschmann has carried out a series of experiments with the object of determining the influence of pain upon blood-pressure (*Münch. Med. Woch.*, October, 1907), and records his results. His method consisted of applying painful electrical stimuli to various groups of individuals, and recording the blood-pressure before and after the application. Twenty individuals with normal sensibility were so tested, and in 18 there was a rise of from 8-10 m.m. of mercury. In persons with a neurotic temperament and a high preliminary blood-pressure the elevation produced was still greater. If the sensibility is disturbed in any way, either as the result of functional or organic disease, the rise in pressure does not take place. M.

Epidemic Pneumonia.—Fabyan writes on the above subject, and points out that while many writers have called attention to cases of pneumonia occurring in groups, the actual occurrence of such cases is comparatively rare. He himself has lately observed such a group, which he now reports (*Johns Hopkins Hosp. Bulletin*, Nov., 1907). The epidemic occurred in a family of ten members, nine of whom were living in the same house. Out of these nine, six members developed acute pneumonia within a period of ten days. Two other members developed an illness characterised by headache and fever, and abdominal pain, within the same period, but no physical signs were found in the lungs. One case proved fatal, and the necropsy showed a typical croupous pneumonia, of a pseudo-lobar type, while from the same individual during life pneumococci were obtained on culture from the circulating blood. It was noted that where two of the patients slept together, the second infection followed the first in each instance in from six to nine days. M.

The Metabolism in Leukæmia Treated by X-Rays.—Finne reports the results of his investigations in four cases of myelogenous leukæmia treated by daily exposure of the splenic region to the X-ray emanations for a period of about 20 minutes (*Russische. Med. Rundschau.*, Heft. 8, 1907). During the treatment frequent blood examinations were made, including counts of the red and white cells, hæmoglobin estimation, and a differential white cell count. At the same time the nitrogenous urinary output was determined, and a quantitative estimation made of the purin substances and uric acid excreted. The writer concludes that the X-rays give much better results than can be obtained by any other treatment, and that in most cases all leukæmic symptoms disappear, so that a complete cure results, at any rate for the time being. The best results are obtained in the myelogenous form of the disease, and they do not appear suddenly, but gradually develop. Apparently the rays influence the disease process itself, but since the etiology is unknown, nothing definite can be stated on this point. The diminution in number of the leucocytes seems to be due to the fact that they are produced in smaller numbers, inasmuch as their diminution goes hand-in-hand with a lessening of the output of purin bodies and uric acid. At the commencement of treatment a decrease in the output of these substances took place, and continued till the leucocytes had fallen to about the normal number. If the exposures were continued after that time, the excretion of purin bodies again increased, apparently due to the destructive effect of the rays on tissue cells of the body. M.

Amaurotic Family Idiocy.—Cohen and Dixon report a case of this disease in which the eyes were enucleated for examination within three hours after death (*Jour. Amer. Med. Assoc.*, May, 1907). The histological changes detected were, swelling of the multipolar ganglion cells, displacement of their nuclei, retraction of cell reticulum, diminution in number of ganglion cells, and disappearance of Nissl's granules. By Weigert's stain, dark granules were found in all the ganglion cells, and it was found that at the macula lutea there were several layers of multipolar cells, while beginning simple atrophy of the optic nerve was also noted. They think it likely that the primary change in the disease is an arrested development, followed by degeneration caused by toxins, the result of defective metabolism. M.

Blood Pressure in Tuberculosis.—Stanton has made a study of the blood pressure in over 200 cases of tuberculosis by means of a modified Riva-Rocci instrument (*Internat. Clinics*, Vol. III., 1907), and has come to the following conclusions:—(1) The blood pressure, both systolic and diastolic, is generally low in tuberculosis, and, as in normal cases, is lower in women than in men; (2) the pressure is higher in improving cases and lower in progressing and unfavourable cases; (3) hæmoptysis is not accompanied by any change in the pressure; (4) the nephritis of tuberculosis apparently does not increase the blood pressure; (5) time of day, presence of fever, degree of involvement, have no influence on the blood pressure of tuberculosis. M.

Diagnosis of Typhoid Fever by the Conjunctival Reaction.—Chantemesse has been experimenting with typhoid fever patients in the hope of discovering an ophthalmic reaction in them similar to what Calmette has described in tuberculous patients when tuberculin is dropped on to the surface of the conjunctiva. He has carried out his observations (*Deutsch. Med. Woch.*, 1907, No. 39) on 120 patients altogether, out of whom 50 were healthy, and 70 were ill with enteric fever. The healthy individuals in all cases failed to react, while a reaction was obtained in all the others, and this reaction was often obtained earlier than the Widal reaction, and was often less equivocal. The writer believes that the reaction gives a new aid to diagnosis, which may be employed and relied on almost as soon as the earliest clinical symptoms are developed. M.

Vaccine Treatment and Diagnosis.—Wright and his colleagues in the Laboratory of St. Mary's Hospital publish (*Lancet*, November 2nd, 1907) "a collection of some of the more interesting" of their records in regard to therapeutic immunisation. The points touched on are very numerous, and we regret that we cannot give a detailed analysis of the paper, which, however, should be read in full. The authors show that auto-inoculation is not infrequent in the beginning of tuberculous infection, and that it is a regular accompaniment of the hectic fever of advanced phthisis. In reference to a case of gonococcal arthritis they show that there is an intimate relation between auto-inoculation and auto-immunisation on the one hand, and the clinical symptoms of the patient on the other. With regard to generalised bacterial infections, they show that spontaneous auto-inoculations and immunising responses are a characteristic feature in anthrax septicæmia as seen in rabbits. The history of their vaccine work in regard to streptococcal and staphylococcal septicæmias is set out in some detail. The authors conclude the first part of their paper by considering the effect of massage and of active muscular movements, the effect of operative interference with the foci of disease, and the effect of active and passive hyperæmia, in producing auto-inoculation and auto-immunisation. In the second part of their paper the authors bring forward evidence to show that in the induction of an auto-inoculation, when this is preceded and followed up by a series of measurements of the opsonic index, there is at hand a method which will aid in some of the diagnostic and therapeutic problems which present themselves for solution in connection with localised infections which are not accessible to direct bacteriological examination. The records and chart contained in the paper are certainly interesting, some of them dramatically so. Particularly are to be noticed certain charts showing a very remarkable parallelism between the opsonic power and the temperature, and between the opsonic power and the symptoms, in various cases. The table of thirty cases where some important question of diagnosis or treatment was answered by the results of auto-inoculation, gives examples of a great variety of cases, and of the dogmatic answers which the authors think were justified. The paper, as a whole, is of great interest, but we are among those who think that selected cases, no matter how striking, do not give a just view of the results of a method of treatment or diagnosis. Vaccine treatment has justified itself, not only in the hands of Wright, but of his disciples all over the world. The necessity for opsonic control is, however, not yet established, and it cannot be so long as Wright publishes only selected cases. Until a full account of the work at St. Mary's is published, including not only ten "more interesting," but all the cases, favourable and unfavourable, if there be any such, no decided opinion can be come to as to the necessity for opsonic control of vaccine treatment. R.

Typhoid Agglutinins in a Non-Typhoid Case.—Symmers and Wilson (*British Medical Journal*, September 21st, 1907) report a case of cerebro spinal fever, in which the blood gave a positive Widal reaction to the typhoid bacillus. The patient was a woman of 27 years of age, who had had no previous illness of any sort for nineteen years, since as a child she had suffered from scarlet fever. It was, therefore, unlikely that she had ever had typhoid fever. Her clinical symptoms were those of cerebro-spinal meningitis, which was epidemic in Belfast at the time of her illness there. Her blood was twice tested as to its agglutinative powers on the *Bacillus typhosus*, and on both occasions the serum in dilutions of 1 in 200 gave marked clumping within fifteen minutes. The illness having ended fatally, an autopsy was performed, and the clinical diagnosis confirmed. There was suppurative meningitis of the brain and cord, and from the pus was recovered in pure culture and in great abundance the *diplococcus intracellularis meningitides* of Wiedaselbaum. An exhaustive bacterioscopic examination of the spleen, mesenteric glands, and urine, was made for the typhoid bacillus, with negative results. There were no lesions of the intestine to suggest typhoid fever; the Peyer's patches being normal. The strain of typhoid bacillus used in Widal's test was that customarily employed in Symmers' laboratory; during the past year it gave in 112 examinations results which, clinically controlled, were considered correct in 97.3 per cent. of the cases. The case recorded is of interest from two points of view—(1) The presence of a typhoid agglutinins in the blood of a case which was not typhoid fever. (2) A possible peculiar property of the serum in cerebro-spinal meningitis on other bacteria than the specific coccus.

The presence of typhoid agglutinins in other conditions than typhoid fever has often been recorded. The present abstractor frequently examined the blood of one of his colleagues who had never had typhoid fever, and who was in robust health; his blood invariably gave positive results to Widal's test, even in high dilutions. R.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

S. R. P. (Croydon).—The method of injecting air subcutaneously for the relief of certain painful manifestations, such as sciatica, was introduced by Dr. Cordier, of Lyons, and the results in the hands of other practitioners has been, on the whole, good—sometimes, indeed, brilliant.

UBIQUE.—Peroxide of hydrogen, in ten-volume strength, has been found very efficacious in cases of epistaxis. A pledget of wool soaked in the fluid is pressed by the finger against the bleeding spot, and after some moments the hæmorrhage generally ceases.

M. D., L. S. A. (Leeds).—Strophanthus acts more quickly upon the heart than digitalis, owing to its being more readily absorbed. Moreover, its action is less irritant.

A COMMON OCCURRENCE.

When a patient calls to see you,
  Very anxious to be cured,
And he quite forgets to fee you—
  Say; now can this be endured?
Take a lesson from the Lawyer;
  He's not one to trust to fate.
No advice, or pen to paper,
  Till he's *sure* of six and eight.
Doctors still are far too willing;
  Free advice should be abhorred.
Public fight about a shilling;
  Go their way: nor thank the Lord!

A. D.

UGANDA.—It cannot be too clearly stated that Dr. Koch no more discovered atoxyl and its value in sleeping sickness than that he discovered the moon. The credit, such as it is, is due to Drs. Thomas and Breinl, of the Liverpool School of Tropical Medicine. According to the newspapers, Dr. Koch discovers everything.

F.R.C.S.Edin.—It is not usual in England to omit "Edin." after F.R.C.S. in cases where the diploma has been obtained in Scotland.

SATURN.—Our correspondent had best arrange a consultation with a specialist in children's diseases.

DR. SYDNEY, W. S.—We shall be pleased to receive the notes, and, as far as our engagements permit, will give them early publication.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 27TH.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. P. Paton: Clinique (Surgical.) 5.15 p.m.: Lecture:—Dr. W. Milligan (Manchester): Some Practical Points in the Treatment of Suppurative Disease of the Nasal Accessory Sinuses.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

THURSDAY, NOVEMBER 28TH.

CHILD STUDY SOCIETY (Parkes Museum, Margaret Street, W.).—8 p.m.: Lecture:—Dr. A. H. Hogarth: The School Clinic.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. P. Horrocks: Profuse Menstruation (with illustrative cases).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture:—Dr. A. E. Giles: Ultimate Results of Inoperable Gynæcological Cases.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Coccus Diseases: I., Impetigo Contagiosa; II., Furuncle; III., Carbuncle; IV., Coccogenic Sycosis.

HOSPITAL FOR SICK CHILDREN (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Thompson: Jaundice in Children.

FRIDAY, NOVEMBER 29TH.

SOCIETY OF ARTS (John Street, Adelphi).—8 p.m.: Shaw Lecture:—Dr. J. S. Haldane: The Hygiene of Work in Compressed Air (Diving, Caisson Work, etc.).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. E. Clarke: Clinique. (Eye.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Appointments.

FALCONER, A. D., M.D.Aberd., M.R.C.P.Lond., House Physician at the Bristol Royal Infirmary.

HIBBERT, C., M.B., Ch.B.Vict., House Surgeon at St. Mary's Hospital, Manchester.

JOSCELYNE, ARTHUR EDWIN, L.R.C.P.Lond., M.R.C.S., L.S.A., Public Vaccinator for Taunton

LACEY, FRANK HAMILTON, M.B., Ch.B.Vict., House Surgeon at St. Mary's Hospital, Manchester.

MEADOWS, GEORGE STEPHEN, M.B., C.M.Edin., Medical Officer for Health of Saltash (Cornwall).

SHEPPARD, ARTHUR LEWIN, M.B., B.S.Durh., Senior Resident Medical Officer at the Bristol Royal Infirmary.

Vacancies.

Castlebar District Lunatic Asylum.—Assistant Medical Officer. Salary £100 per annum, together with annual allowance (including £50 in cash) valued at £100. Applications to Joseph F. Kelly. (See advt.)

Cavan Union.—Medical Officer. Salary £100 per annum. Applications to Joseph Gur, Esq. (See advt.)

Seamen's Hospital Society, Greenwich, S.E.—Medical Superintendent of the Dreadnought Hospital, Greenwich. Salary £200 per annum, with board in the Hospital. Applications to P. Michelli, Secretary.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon. Salary £20 for six months, washing allowance £2 10s., with board and residence in the Hospital. Applications to the Secretary. (See advt.)

London County Asylum, Long Grove, Epsom, Surrey.—Fifth Assistant Medical Officer. Salary £150 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6, Waterloo Place, S.W.

West Riding Asylum, Wakefield.—Assistant Medical Officer. Salary £150 per annum, with apartments, board, washing and attendance. Applications to the Medical Director at the Asylum.

Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C.—Bacteriologist. Salary £120 a year, with lunch in the Hospital. Applications to the Secretary.

Norwich City Asylum, Hellesdon-next-Norwich.—Assistant Medical Officer. Salary, £130 per annum, with rooms, board (no stimulants), laundry, and attendance. Applications to the Medical Superintendent.

Essex County Asylum, Brentwood.—Fourth Assistant Medical Officer. Salary, £150 per annum, with board, etc. Applications to the Medical Superintendent.

Births.

ALLWORTH.—On Nov. 23rd, at "Fairholme," West Hill, Sydenham, the wife of A. Leigh Allworth, M.R.C.S., L.R.C.P., L.D.S., of a son.

BARRY.—On Nov. 19th, at Ashfield Park House, Terenure, the wife of Dr. P. J. Barry of a son.

ELLIS.—On Nov. 19th, at 157, King Henry's Road, South Hampstead, London, the wife of Captain W. F. Ellis, R.A.M.C., of a son.

Marriages.

COLWELL—WOOD.—On Nov. 23rd, at Holy Trinity Church, Stroud Green, London, Hector A. Colwell, M.B., son of Mr. and Mrs. Alfred Colwell, of Ridge Road, Hornsey, to Clara Elizabeth, eldest daughter of Mr. and Mrs. J. Wilson Wood, of Ridge Road, Hornsey.

HAYES—ROYDS.—On Nov. 20th, at Bombay, India, Arthur Herbert Hayes, captain R.A.M.C., son of the Rev. A. H. Hayes, Rector of All Saints', King's Lynn, Norfolk, to Kathleen Mabel, eldest daughter of the late Ernest E. Molyneux Royds, of Rochdale, Lancashire.

Deaths.

HASARD.—On Nov. 20th, at Melbourne, Derbyshire, John Hasard, M.R.C.S., L.S.A., aged 63.

McEWEN.—On Nov. 21, at Pen Rallt, Abergele, Margaret Emma relict of William McEwen, M.D., late of 26, Nicholas Street, Chester.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, DEC. 4, 1907. No. 23

NOTES AND COMMENTS.

Academic and Scientific.

THE annual meeting of the Royal College of Surgeons of England found the Council in still the same spirit of obduracy with regard to the claims of members for representation on the governing body. It seems that the Council, after considerable search for an excuse for the attitude of "what is our own we'll hold," to which they have clung so tenaciously through good and evil report, have lighted on an admirable one, namely, that the "functions of the College are academic and scientific, and are exercised by the Council for the public welfare, and not as a trust received from the members." After this the members may take heart of grace, for if this is the best the Council can say for themselves they must be in a parlous state. It would be interesting to hear how the Council have sought to serve the public welfare, and how much they have sacrificed to that noble ideal. We search our memories in vain for any striking example. The claims of the Council that they are not exercising a trust received from the members is certainly in accordance with its deeds. It does not exercise the trust received from the members at the reconstitution in 1843; but there is no need to glory in the fact. The conception of the Council of the function of the College is weird in the extreme. It is "academic," but it does not teach, it is "scientific," but it does not pursue research. The bulk of its income is received from members' fees, and these it uses not as a trust for the members but for the public welfare. Does the Council really contend that members pay fees in order that the public may be protected from them (the members)? Was ever more disingenuous stuff put forward to bolster up a shaky case?

The "Brown Dog" Disturbances.

THE disturbances among medical students with regard to the "Brown Dog" incident and their treatment by Mr. Paul Taylor, are much to be regretted. If we were to say that they were only the natural outcome of provocation, the phrase would be widely quoted by those papers which delight to calumniate the profession, and we should be accused of "encouraging" the disturbances. We do not say so, but we repeat what we said last week, that the monument and the inscription remain a standing menace to the reputation for good conduct that London medical students have gained. The recent disturbances have allowed to overflow the pent-up hatred felt by certain classes towards medical science and medical men, a hatred which is fomented by certain journals for political ends, regardless of fact, truth, justice, or honour. It is instructive to note the unctuous snobbery of such journals. The medical student, whom they have their knife into, is assailed with abuse and sarcasm, while the young lord who gets drunk and smashes windows, or the budding politician who removes the hands from a public clock, is applauded as a venturesome and dashing fellow. Of the ragging medical student, however, we hear "Is this the sort of man who is to attend our wives and daughters?" or that he is brutalised by vivisection. The Battersea Borough Council, as a whole, would seem to adopt much the same attitude, for the Finance Committee of that body, in presenting its report last week, mentioned that they had gone out of their way to instruct the Town Clerk to convey to the police, and especially to the two officers who arrested the students, the Council's appreciation of their services.

The Better Way.

A CORRESPONDENT of the *Standard*, writing on the subject, expresses with admirable taste the feelings that medical men and physiologists feel with regard to the animals that are experimented on. In remarking on the inscription he says, "Can we be expected to regard this egregious inscription, perpetuated in stone, without some impatience?" and a little later proceeds, "Had the inscription run somewhat as below, it would have been more humane and nearer the truth :—

"In memory of the Brown Dog, who died as he lived, a true friend to man and to his kind. His life taught a lesson of fidelity and devotion to duty, and his death was a sacrifice for the welfare of others like him, and for man, whom he loved.

"People of England, remember this."

Thus speaks the true humanitarian, and the true lover of dogs. His mouth is not froward, and he does not seek to use the regrettable sacrifices that the conditions of life necessitate to impugn the good feeling of those who support experimentation any more than he would seek to impugn that of a general who ordered his army to advance when there was a certainty of loss. But among certain classes the spirit against medical men that has been bred by anti-vivisectionists and others of their kidney, is of a bitterness and malignancy which no one would believe who has not had experience of it.

"Almost Manslaughter."

AT an inquest held at Tottenham the other day, some unusually interesting facts came to light, and we recommend them to the notice of the Committee of the General Medical Council which is to inquire into quackery, and on which we have elsewhere congratulated the new direct representatives of the profession. The facts are that a fish salesman at Billingsgate was pricked in the thumb by the "thorn" of a skate, and suffered from an inflamed finger in consequence. Now it seems that one Gregory, who had been a fish salesman, found surgical practice more lucrative than his own business, in consequence of having acquired a reputation for dealing with poisoned hands with a certain salve and plaster. This salve is stated to have consisted of marsh-mallow leaves, elderberry leaves, and parsley-tops, while the plaster was one of resin and turpentine. To Gregory the wounded salesman resorted and was charged two guineas for the treatment. However, he died of septicæmia. The coroner said that Gregory's treatment was quackery, and it was either crass ignorance or arrogance which led him to take the case up. Indeed, it was "almost manslaughter." The jury censured Gregory, who is, of course, now free to earn many more guineas in the same way, just as he admits having already "cured" hundreds in the market. It would be difficult to find a case better illustrating the conditions of unqualified practice. These salesmen apparently could produce two guineas for Gregory's precious remedies, when a doctor might have got a shilling or half-a-crown, and a hospital nothing. Had the patient been under qualified care the finger would probably not have been allowed to transmit its fatal effects to the system.

A Nose —not Ducal.

An interesting comment on the state of the law with regard to medical practice was furnished by an action in the Westminster County Court last week, when the "Derma Featural Company" sued a Mr. Spencer for the balance of fifteen guineas, £7 of which had been paid, for "building up a new nose." The defendant pleaded infancy, but the plea was disallowed and an order made for the payment of five shillings a month. We do not pretend to know what range of treatment the "Derma Featural Company" undertake, but as one of the advantages of being on the *Medical Register* is that it confers the right to sue for fees for medical treatment, we cannot understand how this Company can successfully use the County Court for the recovery of fees for a surgical operation. It is to us inconceivable that a new nose can be "built up" by other than a cosmetic surgical process, and therefore the *locus standi* of the Company is not apparent. If registrars accept death certificates from unqualified persons, or give burial orders without certificates, and if "Derma Featural" companies can recover fees for surgical operations and medical treatment, the advantages of registration seem to be that a medical practitioner is subject to supervision without any corresponding benefit, whilst outsiders have the advantages without any restrictions.

LEADING ARTICLES.

A PORTENT FROM THE GENERAL MEDICAL COUNCIL.

"The mills of God grind slowly, but they grind exceedingly small," is a comfortable maxim to the philosopher, although it savours too much of procrastination to the man of action. The slow evolution of natural laws in social relations presents us with the series of adjustments and readjustments, sometimes quiet and gradual, sometimes violent and revolutionary, which, taken together, constitute history. As regards the particular subject of medicine, mediæval ignorance has given way to twentieth-century exactitude, and legitimate medical practice has emerged from the craft of the leech, the apothecary, and the barber to the dignity of the duly qualified modern medical practitioner. Side by side with this happy advance there has been no corresponding diminution in the evil work of the quack and the charlatan, whose methods are much the same, whether we read them in black-letter or in the columns of a London newspaper of to-day. The form is somewhat changed, but the substance is the same. The quack of Queen Elizabeth's time was able to deceive his customers with a far less expenditure of capital and brains than is needed by the proprietary medicine vendor of to-day. For many years the "Medical Press and Circular" has almost alone of the medical journals waged an unceasing war against quacks and quackery. In the interests of the public, no less than that of the medical profession, we have done what we conceived to be our duty in the matter, without fear and without favour. In this case it must be admitted that the mills of God have indeed ground exceeding slow, but we trust that within the next generation the curse of medical quackery will be crushed with remorseless grip betwixt the upper and the nether millstones. Of late the subject has been discussed more or less seriously by some of the medical societies and journals. For obvious reasons the lay newspapers, which draw vast revenues from the advertisements of quacks and quackery, will give no hand in the campaign. At length the General Medical Council have taken action in the important matter of unqualified practitioners. Not the old familiar Council, be it noted, as known to us for many years past, but that part of it which comprises the recently elected direct representatives, Dr. Langley Browne, Dr. MacManus, and Dr. Latimer. The original proposition, withdrawn later in favour of another, ran:—

> "That this Council, deeming it to be contrary to the public interest that any person other than duly qualified practitioners in medicine and surgery should practice medicine in Great Britain and Ireland, appoint a Committee to draft such amendments of the Medical Act as may be necessary to secure this prohibition, and to report to the Council at the session in May."

This proposal was met with a not unfamiliar jeremiad from the conservative members of the Council, who talked about the necessary education of the public, the improbability of obtaining legislation, and the vested interests that would be roused into opposition. Finally, however, the following resolution was unanimously adopted:—

> "That a Committee be appointed to report upon all the legal provisions existing in the Colonies and Dependencies of the Empire, and in foreign countries, for the prevention of medical practice by other than legally qualified persons, and to consider what steps should be taken to procure effective legislation for the same purpose in Great Britain and Ireland."

It is to be hoped that this event marks a new era in the history of the General Medical Council. Unless that body becomes inspired with some of the wider and more generous impulses of modern collectivism, it seems not improbable that it will drift into the position of a hopelessly effete administrative instrument. It is not a little significant that this most promising resolution has come from the representatives of the general practitioners. That fact, to our mind, strongly supports the contention that the constitution of the Council demands remodelling on the lines of a representative democratic as against its present individualistic basis. Meanwhile we congratulate the direct representatives on having at any rate fired the first official shot in the campaign. The names of the committee appointed to report are as follows:—Dr. MacManus, Dr. Latimer, Dr. Norman Walker, Dr. Kidd, Dr. Saundby, Sir John Moore, Mr. Henry Morris, and Dr. Langley Browne.

THE CLAIM TO PRIORITY IN TRYPSIN TREATMENT OF CANCER.

THE unwritten laws of the medical world, if at times of a somewhat misty nature, are on some points abundantly clear. One of the clearest of these directions is to avoid, above all things, the discussion of technical medical matters in lay newspapers. That rule has lately been thrown to the winds by certain members of the profession with an audacity and a persistence that is unparalleled in the annals of medical history. In some cases the offenders are engaged in actual practice; in others they may not see patients; but in either event we imagine that it is not altogether improbable that the attention of the General Medical Council will at no distant date be called to this undesirable conduct. On ethical grounds it is not easy to imagine why a man who has scientific facts to discuss prefers to submit them to the judgment of the public while they are still being investigated and criticised by medical men, whose opinion on such matters is alone of value. An instance of the kind may be found in a book recently published by Dr. C. W. Saleeby, an M.D. of the University of Edinburgh, who is generally understood not to be engaged in actual practice, In the book in question, to which our attention was drawn by a correspondent in our last issue, the author lays down the law upon cancer with an emphasis and a conviction that has no rival in the works of scientific surgical authorities. Moreover, he deals freely with the dangerous weapon of personal abuse, a fact that obviously does not strengthen his position. In his desire to attribute the credit of the introduction of trypsin to a non-medical investigator—Dr. Beard, of Edinburgh—he goes to extremes that are calculated to defeat his object. With regard to priority of claim to the trypsin treatment of malignant growths, we have, after careful consideration, ascribed the credit of originality to Dr. J. A. Shaw-Mackenzie. The evidence in favour of that view appears to us overwhelming, and so far as we can ascertain has not been seriously discussed either by Dr. Beard or by Dr. Saleeby. The plain fact of the matter appears to be that both Dr. Shaw-Mackenzie and Dr. Beard arrived at the theoretical value of this special line of treatment by independent routes, but Dr. Shaw-Mackenzie was the first actually to treat patients. It is surprising, therefore, that Dr. Saleeby should in his book attribute absolute priority to Dr. Beard. The allowances that have been made for Dr. Saleeby both by his professional brethren and by the General Medical Council have been great, but the latitude of privilege must necessarily reach a limit when he elects to discuss the action of particular individuals, and he will be at once challenged to make good his statements. In settling a point of priority of claim to a discovery, we must look to something more than the *ex parte* statements of a heated partisan. The clamour and violence of the market-place must give way to the calm and dispassionate investigations of the court of justice. So far the stage thunder seems to have come from Dr. Saleeby, and the argument, clear and supported by documentary evidence, from Dr. Shaw-Mackenzie. It is intolerable that any men claiming the ear of the public as Drs. Beard and Saleeby have done should refrain from substantiating the claim they make to priority, a claim which has already been strongly challenged. If they are to maintain their position as men of honour and responsibility they will either take steps to prove their assertions up to the hilt, or else will withdraw them for all time. The matter is capable of proof or disproof. There appears to be a growing conviction in the orthodox medical world that the trypsin treatment of malignant growths, although not in itself a final solution of the problem, has nevertheless advanced our general conceptions of the nature and treatment of cancer in a way that is not a little noteworthy. For even the faintest ray of light cast upon this mystery all who love humanity and all who are devoted to the pursuit of medicine will be profoundly grateful. In any case we think that the time has come when the claims of Dr. Shaw-Mackenzie in this matter should be authoritatively considered by the medical profession. Possibly the Cancer Research Fund would appoint a committee in conjunction with delegates from some of the leading professional bodies for the purpose of investigation and report.

CURRENT TOPICS.

Colonial Appointments.

THE Colonial medical service may in some instances be worth the attention of young medical men. It is now for the most part essential that the applicant should have gone through a special course of study in tropical medicine. Provided that a man be duly qualified and registered, and can pass an examination of medical fitness, he may apply for a Colonial post. The salary commences (as a rule) at £300, increasing by annual advances of £10 to the sum of £400 per annum. In some cases there are special transit and other allowances, while private practice is permitted so long as it does not prevent the due performance of official duties. Then there is, of course, the further important condition of the ultimate eligibility for pension in accordance with service rules. The suitability of such appointments must always be more or less determined by the temperament of the individual applicant. The great advances in the scientific knowledge of tropical diseases and the present high standard of medical education have added vastly to the attractions of Colonial medical posts in recent years. Those who are likely to entertain the idea of following such a career can obtain full details of all appointments of the kind by applying to the Medical Department of the Colonial Office.

A "New Remedy" for Consumption.

THE *Morning Advertiser* of the 10th ult. announced a new discovery by a "scientist" named A. V. St. Armande, residing at Southend-on-Sea. The remedial agent is a gas which, when inhaled, has the power of suspending ordinary sensation, without interfering with the senses of hearing and speaking. He would be a bold man indeed who would declare the impossibility of the existence of a gas having those curious properties! At the same time it seems more than likely that the news of so remarkable a discovery would have wakened the echoes of the medical world in London and elsewhere. Such a claim is capable of proof or of disproof, and is of such importance to the community that it deserves to be put forthwith to an authoritative test. That remark applies with a thousandfold increase of weight to the further claim of the talented inventor that his gas cures consumption (presumably of the lungs), as well as lupus. Were that the case it would become the bounden duty of the State to secure this marvellous weapon against tuberculosis. If Mr. St. Armande wishes to have his gas tested upon consumptive patients, and can furnish sufficient grounds for the faith that in him lies, we fancy there will be little difficulty in submitting the matter to accurate scientific examination by expert investigators.

Tuberculosis and the Irish Government.

A deputation representative of the chief medical organisations in Ireland and the leading societies concerned in the suppression of tuberculosis, waited on the Lord Lieutenant last week at Dublin Castle for the purpose of urging on the attention of the Irish Government certain points on which legislation is sought. The deputation was introduced by the Countess of Aberdeen, and among the members who spoke were the Presidents of the Royal Colleges, of the Irish Medical Association, and of the Ulster Medical Society. Action was demanded from the Government in four directions—the rendering notification of tuberculosis compulsory, the adoption of more stringent measures for the control of milk and food supplies, the granting of power to the county councils to erect and maintain sanatoria and dispensaries, and the inauguration of a proper system for the inspection of schools. No one who knows anything of the condition of Ireland as regards sanitary matters can doubt that reform in all these directions is urgently needed. In all of them Ireland lags far behind the rest of the kingdom, and, as a result, the mortality from tuberculosis is much higher than elsewhere. As was to be expected, the deputation received a sympathetic hearing from the Lord Lieutenant, the Chief Secretary, and the Vice-President of the Department of Agriculture. Mr. Birrell promised that the Government would do its best to give effect to the representations of the deputation as early as possible, and perhaps it was impossible for him to be any more definite. Mr. Russell, however, was able to make a definite statement of much importance, though only touching on one of the points raised. He said that in the County Wexford, under the Department of Agriculture, there was being carried out a system of veterinary inspection, by which it was proposed to apply the principle of the Medical Charities Act to the diseases of animals. If the experiment succeeded in Wexford, there was no reason why it might not be applied in other counties. We trust that no opportunity may be lost of forcing the serious points raised on the attention of the Government.

Dirty Dublin.

In a speech the other day at the inauguration of the Dublin Branch of the Women's National Health Society of Ireland, the Dean of St. Patrick's very properly referred to the dirty condition of the streets of Dublin, and the evil influence of that condition on the health of the citizens. Without the excuse of thick smoke or heavy fogs, Dublin is without doubt one of the most dirty cities in the kingdom. No feature of the city so strikes a stranger, or a resident after a period of absence, on entering Dublin, as the uncleansed condition of the streets. In many of the Continental cities, and in London and the great cities of England, men or boys are constantly employed in keeping the streets clean. Horse-droppings are immediately removed with brush and shovel and no refuse is permitted to lie in the street. In Dublin no attention is paid to matters of the sort. Horse-droppings, scraps of paper, garbage of all sorts, and mud of the streets, are beaten together by wheels and feet till after nightfall, when the streets may or may not be swept, and the sweepings may or may not be carted away. In dry weather the same sweeping-machine is used, without any previous watering of the streets, with the result that dust is blown in eddies to the bedroom windows, carrying indescribable filth to the lungs of any sleepers who may leave their windows open. It is as a result of the carelessness shown by the sanitary authorities in such matters as this, that Dublin retains its position as one of the most unhealthy cities in Europe.

Florence Nightingale, O.M.

The raising of Florence Nightingale to the Order of Merit has awakened as much pleasure as surprise in the country, for though she is old, indeed nearly ninety, the memory of her heroism and goodness still shines brightly in every British home. We venture to think that there is no other woman whose appointment to the Order could have passed without challenge, but every paper in the land has nothing but praise and congratulation for Miss Nightingale's inclusion. To ourselves it is a particular pleasure and privilege to add our tribute to those already bestowed on the venerable lady, who, already enshrined as a saint in America, in this country is in actuality, if not by canonisation, the patron saint of modern nursing. Florence Nightingale's career is one of such peculiar beauty and merit that it awakens good in all who contemplate it. In all her struggles and official combats she never forgot her womanliness, and her capacity as an organiser was never allowed to obscure the fact that she was a true, tender-hearted nurse. There was nothing of the arm-chair sentimentalist about her, but she was always a living and practical power. When we consider how "honours" are bestowed, we should have resented at most any of the ordinary distinctions being conferred on Miss Nightingale, but to have placed her in the Order of Merit shows on the part of the Prime Minister an appreciation of the fitness of things which is wonderfully to his credit. That Miss Nightingale may long be spared to wear her insignia, and that her place among the immortals may help to keep green the memory of her goodness, we most heartily wish.

Spurious Sports.

It were well for those who love the lower animals to divert their attention from experimental researches, which are conducted in the highest spirit of altruistic science, to the horrors that are daily committed upon the brute creation merely to satisfy the lust of sport. The sentimentalists who cut such a sorry figure over the "Little Brown Dog of Battersea," and the monumental record of a failure to prove their statements when tested in a British court of law, will find abundance of maimed lower animal life in the shape of rabbits, deer, pigeons, and so on, to perpetuate in bronze and marble. Let them lay to heart the following resolution framed recently by the Royal Society for the Prevention of Cruelty to Animals:—"That this meeting," it ran, "representing branches of the R.S.P.C.A., kindred organisations for preventing cruelty to animals, ethical and other societies, and individuals of various schools of thought, desires to record its strong conviction that the time has come when certain spurious sports, to wit, the hunting of carted deer, the coursing of captured rabbits, and the shooting of birds from traps, should be forbidden by law, as being not only wantonly cruel to the animals thus hunted, coursed, or shot, under wholly artificial conditions, but also demoralising to those who practise or witness such things; and appeals to his Majesty's Government to grant facilities in the coming Session for a discussion of the Spurious Sports Bill, which would render these degrading pastimes illegal." The Hon. Stephen Coleridge, in supporting the resolution, was careful to point out that it was absurd to say they were not to put down one kind of cruelty until they had put down all kinds. But why does not Mr. Coleridge, so to speak, begin at home, that is to say, with cruelty committed for the sake of sport, of personal decoration, and in mere wantonness of slaughter?

The People and the Hospitals.

The continuous readjustment of our social relations is a necessary consequence of the laws that govern the evolution of society. Where from any cause the gradual changes attendant on such a process are arrested, things are apt to right themselves in the disastrous upheaval that is termed a revolution. Fortunately, a crisis of that kind seems foreign to the British genius and temperament, in spite of the political agitation that has recently been raised against Socialism and all its works. As a matter of fact, there is a good or Christian socialism, and a bad or nihilistic socialism, which require to be carefully distinguished. But every member of the poorer classes of the community, whatever his political or his social creed, must reckon with the enormous amount of money directly and voluntarily given by the wealthier classes to the medical charities. Incidentally a corresponding amount of gratitude is due to the medical profession, which provides gratuitous service to the hospitals. The extent of the benefaction may be estimated from the statement that in London alone one out of every three or four of its inhabitants resorts to those institutions in the course of each year. In some socialistic quarters it is the fashion to clamour for public supervision of these privately-subscribed funds. On general grounds there is no particular reason why a well-devised central control of some kind should not be instituted. Indeed, to a partial extent, the principle is being enforced by the various Hospital Funds of the United Kingdom.

PERSONAL.

Miss **Florence Nightingale** has been gazetted to the Order of Merit by the King. Miss Nightingale is the first woman to receive the distinction.

Princess Christian, president of the Liverpool School of Tropical Medicine, paid a private visit to the school on November 27th, and was conducted over each department by the various heads.

Dr. George Williamson has been elected President of the Aberdeen Medico-Chirurgical Society.

Mr. Haffkine, C.I.E., has been offered and has accepted an appointment under the Indian Government.

Dr. Edwin Bramwell, son of Dr. Byrom Bramwell, has been elected Assistant Physician to the Edinburgh Royal Infirmary.

Dr. G. W. Watson has been appointed Physician to the Leeds Public Dispensary, in succession to Dr. Wardrop Griffith, appointed Consulting Physician.

It is said that the Nobel Prize of £8,000 is to be awarded to Professor Laveran in recognition of his studies on Paludism.

Professor Wright, M.Sc., of Leeds, has had the title of Emeritus Professor of Midwifery conferred on him on his resignation of the active chair in that subject.

Professor John Ferguson, M.A., LL.D., will preside at the Glasgow University annual dinner at the Trocadero Restaurant, W., on Friday, December 6th, at 7.30 p.m.

The Bradshaw Lecture of the Royal College of Surgeons of England will be delivered by Rickman J. Godlee, Esq., M.S., F.R.C.S., on Friday, December 6th, at 5 o'clock.

Colonel G. D. Bourke, C.B., R.A.M.C., has been selected to succeed Surgeon-General J. D. Edge, C.B., R.A.M.C., as principal Medical Officer of the Irish Command next May.

Dr. Abraham Ellenbogen has been presented by the B. Division of the Liverpool police with an illuminated address in recognition of his professional skill in saving the life of a badly wounded constable.

A statement that was published to the effect that the King would probably visit West Wales at Eastertide to open the Alltymynydd Consumption Sanatorium is unfounded. Princess Christian will probably perform the ceremony.

Mr. Jameson Evans, Surgeon to the Birmingham and Midland Eye Hospital, will deliver the Richard Middlemore Post-Graduate Lecture for 1907 at that hospital on December 12th, at 4.30 p.m. The subject is "The Prophylactic Measures in Ophthalmology."

Mr. John Murray, F.R.C.S., has been appointed surgeon, and Mr. Gordon Taylor, M.A., B.Sc., M.B., M.S., F.R.C.S., has been appointed assistant surgeon to Middlesex Hospital, vice Mr. Andrew Clark, F.R.C.S., who has resigned on account of ill health.

Mr. Thomas Donovan, a member of the Cork Municipal Corporation, has undertaken that if, during the coming session of Parliament, a Bill is passed creating the Queen's College, Cork, a University for the South of Ireland, he will contribute towards its funds the sum of £1,000.

The Arnott Memorial Medal has been awarded by the Irish Medical Schools and Graduates Association to Sir R. Havelock Charles, Physician-in-Ordinary to the Prince of Wales, in recognition of the great advances he made in the technique of the surgical treatment of certain endemic diseases in India.

Mr. Chamberlain has received the following telegram:—"We, as president and chairman of the Liverpool School of Tropical Medicine, desire, on behalf of the school, to ask your acceptance of the Mary Kingsley medal, founded by the school in memory of the late Mary Kingsley for presentation to those who have specially distinguished themselves in the noble cause of the amelioration of health conditions in the tropics—a cause which you personally have so much helped.—Princess Christian of Schleswig-Holstein, President; Alfred Jones, Chairman."

A Clinical Lecture

ON

EXOPHTHALMIC GOITRE AND MYXŒDEMA. (a)

By R. W. PHILIP, M.A., M.D., F.R.C.P., F.R.S.E.,

Physician and Lecturer on Clinical Medicine, Royal Infirmary, Edinburgh.

Gentlemen,—I propose to-day to ask your attention to two cases which have a certain etiological and clinical relationship, and which present certain remarkable contrasts. The first is a case of exophthalmic goitre, and the second is one of myxœdema. Both cases are highly illustrative, not merely of the main features of these diseases, but of certain aberrations from the more typical clinical type. As you are aware, the prevailing view at present is to regard these two diseases as expressions of two different aspects of disturbance of the function of the thyroid gland.

Without going into minute details, it is sufficient for our present purpose to recall that the thyroid gland seems to have, as one of its functions at least, the elaboration and secretion into the blood-stream of a certain substance necessary for healthy metabolism. I shall not stay at this point to discuss with you the nature of that substance, or its exact action in the normal subject. Apparently the amount of the substance elaborated and secreted is most carefully regulated by some mechanism about which we can only theorise. Certain it is that from time to time disturbance in this finely adjusted arrangement takes place. This may be in one of two directions. Either an excess of the substance is allowed to pass into the blood—whether from over-elaboration or extra secretion we need not discuss for the moment—or, on the other hand, too little of the substance is supplied. In the one instance we have the condition which may be described in a word as hyperthyrea, and in the other we have the condition which may be described as athyrea (or hypothyrea). Returning to the two cases before us, there is considerable reason for regarding exophthalmic goitre as essentially a condition of hyperthyrea, and myxœdema as essentially a condition of athyrea.

With this general introduction we may pass to a short account of the history and leading symptoms of the individual cases.

Case I.—Mrs. H., æt. 47, a seamstress, was admitted to Ward 33 on September 27th. Her chief complaint was projection of the eyeballs, nervousness and general weakness.

History.—About 10 years ago the patient suffered from severe nervous shock. Owing to domestic disturbance, she was suddenly subjected to intense worry and to quite unwonted strain in the way of work. For two or three years, apparently, she worked the greater part of day and night, four days a week. Two years after the advent of the severe shock, it was noticed that her right eye seemed to project unusually. About a month later the patient noticed her throat to be "swollen," as she puts it, and she began to be troubled with palpitation, at first on exertion, and then latterly from very slight cause. She became so nervous that when the bell rang she was unable to open the door. On a number of occasions she had fainting turns, either complete or partial. From time to time a feeling of grave dread seized her which quite unnerved her. Throughout this period the projection of the eyes became more definite. This continued to be more marked on the right side, but the left came to project almost to the same extent. There was a gradual advance of symptoms during the eight years referred to, with alternating periods of remission and subsequent exacerbation of symptoms. About three months ago—the date corresponding approximately with the onset of the climacteric—she became rapidly worse. The nervousness got extreme, and on one occasion she fell down in the street, believing that she was dead. Of previous illnesses, we may note that 10 years ago she was operated on for an ovarian tumour, which was removed. A year or so later she had an illness of six weeks standing, which is described as rheumatic fever. She has had other rheumatic manifestations. She had pleurisy, with effusion, 10 months ago, and apparently congestion of the lungs when she was a child. In the family history there is little of importance. She has one son, alive and well. One child was born prematurely at five months. There have been no miscarriages.

In the above history I shall ask you to note that the patient, who is now 47 years of age, was at the commencement of her illness rather beyond the age at which exophthalmic goitre is most common—that is, between the twentieth and thirtieth year. As you remember, the disease is more frequent in women than in men. You will note also the precedent rheumatic history. The frequency of this has been emphasised by Robinson and others, who have based thereon treatment by salicylates.

The present case affords a striking example of what seems truly to be the commonest exciting cause of the disease—namely, mental disturbance, worry and depressing influences.

Passing now to her present condition, the most remarkable feature is the exophthalmos. You have doubtless seen examples of the condition before. You probably never have seen it in more extreme degree. It may be convenient to consider to what extent the recognised features of the disease are present in the given case, and to amplify the clinical picture by anything that may be special to the case.

1.—Exophthalmos.

In the present instance this is, as it is most commonly, bi-lateral. It is extreme, and is more pronounced on the right side, which we have just seen was the side first affected. The eyeballs are so projected that one feels as if, on excitement or effort, they might be completely dislocated. There is the characteristic staring aspect, produced, as you know, through the presence of the white ring of sclerotic round the pupil. The upper eyelid is conspicuously retracted, so that the palpebral aperture is much greater than usual (Stellwag's sign). As the patient casts her eye downwards, there is a hesitancy in the downward movement of the upper lid, so that the sclerotic above the pupil is further exposed (Von Graefe's sign). In this particular case, the retraction of the upper eyelid and the projection of the eyeball is so great that the cornea has become inflamed. There has been recurrent keratitis and ulceration of the cornea. Closure of the lids at night is not quite complete, so that special measures have had to be taken to protect the eyeball. There is interference with the natural convergence of the eyeballs (Moebius' sign). Accommodation is undisturbed, and there is no interference with sight. The pupils and the optic nerve seem natural.

2.—Thyroid Enlargement.

This is not very conspicuous. There is, however, some general enlargement of the organ. The right lobe is rather more affected. The swelling is soft and elastic to the touch. There is no marked thrill, and only a slight systolic bruit on auscultation. The patient reports that the enlargement of the gland was considerably more at one time.

[(a) Delivered in the Royal Infirmary, Edinburgh, Nov. 8th, 1907.]

3.—CIRCULATORY DISTURBANCE.

This is marked. Palpitation, dyspnœa, and tendency to faint have been conspicuous, more especially on exertion or excitement. There has also been some swelling of the feet. The pulse rate on admission was 128, and has varied from that to 92 yesterday. The pulse is of medium size. At first the systolic pressure was conspicuously high, reaching as much as 210 mm. Hg. (Riva-Rocci's sphygmomanometer). There is more or less arterial throbbing. The heart's action is quick, forcible and rather diffuse. Auscultation reveals the presence of a systolic murmur, heard especially in the mitral area and propagated towards the axilla.

4.—NEURO-MUSCULAR PHENOMENA.

The patient is very nervous and excitable. On this account I have kept her quietly in a side ward. Fine muscular tremors are observable in the hands and fore-arms. As compared with many such sufferers, the patient is not thin. Indeed, her general condition externally would attract little remark. She is not conspicuously pallid, nor is there much evidence of pigmentation. Flushing of the skin occurs readily, and generally the skin feels rather moist. The appetite is good, and digestion is natural. Patient's intelligence is quick, and the other cerebral functions appear normal.

Before we pass to Case II., I should like to read to you the earliest description of exophthalmic goitre which occurs in literature—I mean that by Dr. Caleb Hillier Parry, of Bath. It occurs in his posthumous works, published in 1825. The observations were made much earlier. He draws attention to the coincidence of enlargement of the thyroid gland with enlargement and palpitation of the heart, and proceeds to give illustrative cases as follows:—

"The first case of this coincidence which I witnessed was that of Grace B., a married woman, æt. 37, in the month of August, 1786. Six years before this period she caught cold in lying-in, and for a month suffered under a very acute rheumatic fever, subsequently to which she became subject to more or less of palpitation of the heart, very much augmented by bodily exercise, and gradually increasing in force and frequency till my attendance, when it was so vehement that each systole of the heart shook the whole thorax. Her pulse was 156 in a minute, very full and hard, alike in both wrists, irregular as to strength, and intermitting at least once in six beats. She had no cough, tendency to faintness, or blueness of the skin, but had twice or thrice been seized in the night with a sense of constriction and difficulty of breathing, which was attended with a spitting of a small quantity of blood. She described herself also as having frequent and violent stitches of pain about the lower part of the sternum.

"About three months after lying-in, while she was suckling her child, a lump of about the size of a walnut was perceived on the right side of her neck. This continued to enlarge till the period of my attendance, when it occupied both sides of her neck, so as to have reached an enormous size, projecting forwards before the margin of the lower jaw. The part swollen was the thyroid gland. The carotid arteries on each side were greatly distended; the eyes were protruded from their sockets, and the countenance exhibited an appearance of agitation and distress, especially on any muscular exertion, which I have rarely seen equalled. She suffered no pain in her head, but was frequently affected with giddiness."

Could you wish, gentlemen, for any more vivid description? And, mark you, the record is of a case seen fifty years before Graves or Basedow wrote of the disease. It is curious to find that both these names have become associated closely with it, while if any name deserves to be kept in memory in relation to exophthalmic goitre, most certainly it is that of Caleb Hillier Parry.

CASE II.—Mrs. M., æt. 40, keeps her own house, was admitted to Ward 33 on October 16th. Her chief complaint was general swelling, which had been increasing for some years.

History.—Six years ago, shortly after the birth of her last child, the patient noticed that she was getting stouter. Her clothes felt tight and small, and her friends remarked that she was getting bigger-looking. The swelling gradually increased, affecting the whole body—face, arms and legs, as well as the trunk. She was not only fatter, but there was a feeling of stiffness in the skin. She noticed about the same time that her hair was becoming dry and brittle, and fell out. She experienced advancing weakness and disinclination for physical and mental effort, shortness of breath and headache. Her memory, which previously had been excellent, tended to fail. She found that she forgot things easily which previously she could not have failed to remember. From time to time she found herself stopping in conversation because she seemed to have forgotten what she wished to say. There is little in the previous history of importance. For the last 20 years she has had no serious illness. The family history is similarly satisfactory. There is no history of tuberculosis. There has been some slight rheumatic tendency. She has had nine children, all of whom are alive and well. There have been two miscarriages, respectively four and two years ago. She has always been in comfortable circumstances. Perhaps the most noteworthy point in the history concerns her reproductive activity. She is only 40 years of age, and has had 11 pregnancies. Frequency of pregnancy has been cited as a determining influence by some observers.

As to her present condition, certain of the features are less striking than they were ten days ago, for the reason that the patient has been undergoing special treatment, to which I shall refer presently. The appearances are, however, characteristic. The face is conspicuously broad and expressionless, and the neck and shoulders much thickened. Similarly the hands are swollen and broadened. The fingers have lost their expression, and have become uniformly thick. The whole hand has what has been described as a "spade-like" aspect. These remarks apply also generally to the feet. The cutaneous tissues have a firm resistant character. There is no pitting on pressure. The skin of the face is pallid and rather yellow, with a bright red spot in the malar region. The lips, which are rosy, have a distinctly livid tinge. The skin is markedly dry and harsh. Perspiration is wanting. The hair is dry and brittle, and has a coarse aspect, and, as you have heard, has been falling out. The nails show nothing unusual. The teeth have almost all gone through caries. The thyroid gland is small and hardly determinable. The appetite is poor. The tongue is remarkably large.

The expression of the patient is dull and heavy; a fortnight ago it was very much more so. The patient has the strange consciousness of being stiff. Mental activity similarly is languid. Memory is certainly defective. The speech is not conspicuously disturbed. The urine contained .218 gr. albumin per ounce on admission, but this has disappeared. The mean pulse rate during three weeks has been 84. The temperature has ranged from 96.3° to 98°. The patient feels cold readily.

If we rehearse, then, the leading points in relation to these cases, the remarkable contrast strikes us at once. In Case No. I., there is the highly nervous, sensitive, almost irritable aspect, with the staring gaze from the widely separated lids and protruding eyeballs. In the other case there is the ultra-placid, even dull and lethargic aspect, with the heavy look about the eyes, which are seemingly deep-set behind heavy, thickened eyelids. In No. 1, the whole neuro-muscular system seems in a state of flux and vibration, while in the other case the tissues seem fixed as in a gelatine cast, which renders impossible all finer vibratory movement. And what applies to the external aspects of the patients applies similarly to so-called intellectual motions. There is no need to elaborate this point further. It is evident from all we have seen. Then in Case No. I., there is enlargement of the thyroid gland, less, it is true, than often in such cases, but still definite. In the other case the thyroid gland is hardly, if at all, determinable. Lastly, in the first case the circulation is rapid, full and excitable, the skin surfaces are warm and moist, while in the other case the circulation is sluggish, superficial surfaces are cold, dry, harsh, and the cutaneous appendages in a state of low vitality.

So much for points of contrast. The common meeting-ground for the two cases is the thyroid gland. In both cases there is evident disturbance in size, though in opposite directions, and we have abundant reason to say disturbance in function also. In the first case the gland is much enlarged, and as histological examination shows, is in a state of active proliferation, with corresponding increase of functional activity. In the other case, the gland is in a state of partial, or maybe complete, atrophy, with corresponding reduction in functional value. This common meeting-ground, with the two opposing aspects of excessive activity (hyperthyrea) and reduced activity (athyrea), affords the basis for the now generally accepted line of treatment in the two cases.

In myxœdema (athyrea), of which Case No. II. is a good illustration, the therapeutic indication is to endeavour to compensate for the insufficient activity of the thyroid gland by the introduction of thyroid extract, obtained artificially from another animal. The procedure first proposed by Horsley and Murray is now so generally accepted that I need not dwell on the matter in detail. Liquid and solid extracts are obtained from the thyroid of the sheep, and are administered subcutaneously or by the mouth. In ordinary cases we make use of thyroid feeding, and commence with 1 to 5 gr. of the solid thyroid extract, three times a day. In the present instance the patient, after a fortnight's observation, received 5 gr. of the extract thrice daily. She has had this for nine days, with the remarkable result that already her aspect is much more natural, her expression more lively, her mental activities keener, and she has dropped 7½ lbs. (a) —that is, almost 1 lb. per diem. In addition to this, the albumin has quite disappeared from the urine, and the hair has assumed a more natural appearance.

On the other hand, in exophthalmic goitre, of which Case No. I. is so striking an example, many lines of procedure have been suggested. Restricting ourselves, however, to-day to its dependence on thyroidal disturbance, the question arises how we are best to meet this? In the foreground we may exclude the use of thyroid extract which has been actually proposed. I say we may exclude the use of thyroid extract as likely rather to intensify than to improve the symptoms. By a curious paradox, however, benefit appears to have followed its use in some cases. In this connection I may remind you that sometimes myxœdema follows on exophthalmic goitre. It is conceivable that for such transitional cases thyroid extract should prove serviceable. Still, exophthalmic goitre recalls so definitely in various ways the effects produced by over-dosage with thyroid extract that it seems undesirable to proceed in most cases to treat exophthalmic goitre in this fashion.

The assumption has been made, however, that, in the condition of myxœdema which is so remarkably benefited by the exhibition of thyroid extract, there must be present in the circulation some product which is opposed to and neutralised by thyroid extract. If, then, myxœdema be artificially induced in an animal, say the goat—that is to say, if the thyroid gland be removed and the condition known as cachexia strumipriva be established, there is produced within the circulating blood a certain quantity of this principle, antagonistic in action to the thyroid secretion. If, then, the serum of such an animal be removed and administered to the patient suffering from hyperthyrea—excess of thyroidal secretion—the assumption is that the latter is antagonised, and once more a state of equilibrium restored. Such a serum has been prepared under the direction of Moebius, to whom I have already referred, and is known as "antithyroid serum" (Moebius). It is exhibited in doses of from 10 to 60 minims, and is conveniently given in milk, or it may be in wine.

This treatment was commenced eight days ago in Case No. I., after the patient had been treated for five or six weeks on the older lines of rest and cardiac and other tonics. We began with 10 minims of the antithyroid serum twice daily, and the dose is being gradually increased. In the interval a certain improvement has been noticed, both by us and the patient herself. It remains to be seen to what extent the effects are traceable to the treatment, and whether they are progressive. Perhaps on some future occasion I may have the opportunity of referring to this point. It seems to me that much may be said for the plan, both from the theoretical point of view and practically from results I have obtained by the method in more than one case already. The results, both in my own hands and in those of other observers, have, however, not been constant. We must admit that the method is still on trial.

The two cases I have presented to you to-day afford, then, a particularly interesting study, not merely in relation to their clinical features and pathological relationships, but also in respect of their scientific treatment. I would have you note, however, that in thus considering the two diseases in relation to the thyroid gland, we are still far from an exhaustive conception, either of their pathology or their treatment.

Admitting that a certain number of symptoms occur together with sufficient regularity to justify their being grouped as a distinct disease, which we call, on the one hand, exophthalmic goitre, and on the other myxœdema, we are still at sea regarding the ultimate cause of the mechanism of production. The history of many cases of exophthalmic goitre points to the nervous system as the primary seat of disturbance. The disease would thus seem to be traumatic in origin, using that term in a wide sense. The subsequent steps in causation still require elucidation. Even the order of clinical events is different in different cases. Murray's statistics indicate that, in the majority of instances, the first morbid appearance is to be found in the thyroid gland, which becomes enlarged. Later, it may be years after, the circulatory excitement appears, and then still later the exophthalmos, and the more general neuro-muscular disturbance. I need hardly remind you that even if this order of events be accepted as the more frequent one, the traumatic origin of the disease—that is, the relation of the disease to nerve-shock—is in no wise prejudiced.

There are probably other channels through which the disturbance of the thyroid gland is produced and maintained, as in the case of other organs. While the more evident clinical manifestation is more or less uniform, there may be considerable diversity of causation. Such diversity of causation may, after all, explain the seeming paradoxes to which I have referred in relation to treatment. And what applies to our conception of exophthalmic goitre applies, *mutatis mutandis*, to that of myxœdema.

The treatment which has been proposed for both diseases, so far as we have discussed it to-day, is not, in the true sense, an ultimate one. It is rather a matter of compensation than of cure. Remove the myxœdematous patient from his daily dose of thyroid extract and he steps back quickly into the old state. The process of compensation must be maintained, apparently, in some degree, for the rest of his life. And so, perhaps, in respect of the treatment which we have discussed for exophthalmic goitre.

In a certain way the treatment presents analogy with the treatment of diabetes. We antagonise, we neutralise, we minimise certain morbid manifestations, but in the majority of cases we fail to cure. We want to get still farther behind the scenes, and, if possible, correct the faulty mechanism (disturbed innervation?) on which the defect in the secretory function depends.

It remains for me to make reference to an evident application of treatment which Case No. I. illustrates. Here the protrusion of the eyeball, as we have seen, is so extreme that injury is apt to accrue, not only by day, but also by night, when the eyelids fail to close completely. In the present instance, inflammation and ulceration of the cornea has ensued. To obviate this, it is desirable to arrange a splint of plaster, especially for night use, which passes from the upper edge of the upper eyelid down to the upper level of the malar region. Thereby the eyelids are kept closed.

It has been suggested that in such pronounced cases the proper course to follow is to practise partial enucleation of the thyroid gland. Unfortunately, two difficulties confront us in this connection. In the first place the operation is a serious one. Statistics are less favourable than the patient might desire. Thus Mayo's statistics show that, of 40 patients operated on, 6—that is, 15 per cent.—died as a direct result of the surgical operation, 25 per cent. were partially improved, and 50 per cent. were so much improved that a cure might be spoken of. In the second place, in the patient before us, the thyroid gland is now comparatively little enlarged, and has been getting smaller, while there has been no simultaneous improvement in relation to the exophthalmos. So definite has been the diminution in size of the thyroid, that, taken along with one or two other manifestations in the patient's aspect, etc., the query has passed through my mind whether we may not see realised in this particular case the transition from a case of exophthalmic goitre to one of myxœdema.

(a) Three weeks later she had dropped as much as 21¾ lbs.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Macleod Yearsley, F.R.C.S., Senior Surgeon to the Royal Ear Hospital. Subject: "Otosclerosis."*

ORIGINAL PAPERS.

HIGH FREQUENCY EFFLUVATION AND SPARKING IN THE TREATMENT OF MALIGNANT TUMOURS. (a)

By Dr. J. A. RIVIERE,

Paris.

[Specially Reported for this Journal.]

At the present time, when many eminent surgeons acknowledge the efficacy of physico-therapeutics, I wish again to bring forward the propositions I was the first to assert in 1900 and 1903.

Certainly, in spite of the wavering condition of actual therapeutics, in spite of the fatalism existing in the theories on the obligatory increase of malignant tumours, I deem that the cures (pretty numerous), and the numberless very grave cases in which improvement has been obtained by the aid of physico-therapeutics, should make us regard as culpable negligence the fact that no recourse has been had to these agents which pre-eminently have a local and general modifying effect, all the more so because, when in the hands of experienced medical men, they present no danger and give rise to no inconvenience.

On those lines I wish to bring before this Congress a useful contribution by summing up my observations of more than ten years, and to demonstrate plainly at this meeting the results of my clinical experience.

Amongst the physico-therapeutic agents whose action is the most remarkable, I must, above all, point to high frequency and high tension effluves and sparks. The regulation of their activity is pretty easy, according to the case. I preferably employ the long currents and the bipolar sparks when it is necessary to act on tumours deeply situated, reserving for epitheliomata the monopolar applications. At the International Congress of Medical Electricity and Radiology (Paris, July, 1900), I gave an account of my first successes by this method. I mentioned them again in 1903 in a communication to the Academy of Medicine, the importance of which was supported by numerous observations and by the presentation of several patients.

In these communications, where for the first time in radiology the diagnosis was sustained by a histological examination, I was the first to assert that which has since been confirmed—namely, that the high frequency effluves and sparks cure both superficial and deep malignant tumours; that they destroy the neoplastic masses, whilst they respect the healthy tissues; that their action on lymphoid tumours is most marked; that they should, in conjunction with the Röntgen rays, when employed after operations, serve to prevent recurrence of malignant tumours; that physico-therapy is the one and only resource in cases of inoperable tumours; that the strength of the Röntgen rays can be very great without producing impairment of the tissues; that occasionally the actinodermatitis seems to hasten and to favour the cure; that it is indispensable to push the treatment as far as elimination of the necrosed parts, then to come back to the general circulation; that the neoplastic cell does not derive any benefit from the synergic forces of the healthy cells under the influence of the nervous system; that it is always necessary to pay great attention to the patient's general condition, as well as to the treatment of the local lesion; that in the presence of a disease as tenacious and grave as cancer, the medical man should know how to accommodate the power of the treatment to the resistance of the disease, and so bring judiciously into play all the resources of the physico-therapeutic armamentarium.

Since that period, without abandoning the use of the Röntgen rays, but faithful to my first convictions, I have, within the knowledge of my colleagues, given the first place in treatment to the high-frequency effluves and sparks as being more reliable and more conclusive. However, according to my usual method (which since 1901 I have many times explained to learned societies and also in the Annals of Physicotherapy), I regard as legitimate (and, going still farther, as indispensable) the therapeutical alternation and superposition of the various physico-therapeutic agents in order to obtain a cure. The medical man, dealing with pharmacology, does he not vary, and at the same time bring together, his authoritative or galenic formulæ? The surgeon, always anxious to carry out antiseptic methods, does he not know how to successfully combine the different resources of materia medica so as to multiply the curative action with a minimum of possible inconvenience? In the same way the physico-therapeutic expert should know, when he realises that the action of one of his remedies is exhausted, how to have recourse to another in order to perfect a complete cure. (Here we have a point of observation the explanation of which can be found even in the warfare between the cells.) This cure, thus considered, terminates, even in the most hopeless cases, in a lessening of the pain, in resolution of the tumour, in improvement of the dyscrasic condition, in re-establishment of the nutritive equilibrium. I have not thought it necessary to employ chloroform and the curette, as later on my confrère, Dr. Keating Hart, has done. The apparatus I have used, all differing in their mode of production and in their intensity, are the best and the most powerful made up to the present date, and I have always maintained that the patient can bear without pain the longest effluves and sparking on condition that these last are not too strong. Those high-frequency sparks and effluves, the different productive arrangement of which allow of variations in their application, are the ones which exercise an elective action on the neoplastic cell.

Between the spark and the effluve there only exists a question in degree of concentration in the strength of the high-frequency. The effluve is a spark divided into more or less fine rain-like spray; it is emitted from an electrode bristling with points, whilst on the other hand the spark is given off from one point only. The effluves and the sparks, thanks to the perfected apparatus I have made use of, can be short or long, scarce or in large numbers, fine or dense; for this it is merely necessary to alter the working of the apparatus. An even better plan is to have at one's disposal, as I myself have, several apparatus of different construction. There are various shades of dissimilarity between different sparks and effluves, according to whether they are short, fine, long or dense. The short, warm sparks of great strength are the ones that exercise the thermo-electro-chemical action of which I spoke in 1900. They destroy the neoplastic masses, and their action proceeds from the periphery to the centre. These sparks, which are derived especially from the small solenoid or even from the primary part of the resonator, cause pain. The long sparks and effluves act by percussion, and their effect is deep. Their action from a certain distance is necessary for the disorganisation of the deep neoplastic cells. The short sparks that are taken up by the small solenoid act specially by their ampérage. The long effluves or the sparks taken up by the secondary part of the resonator act, above all, by their voltage, which can attain 300,000 volts, or 600 watts. The strength of the transformators, the capacity of the condensators, the relations of the different capacities when brought face to face, the length and the diameter of the conduction wires, are so many factors which intervene to modify the condition of the sparks and of the effluves.

(a) Read before the French Medical Congress, Paris, Oct. 14-16, 1907.

As I have always pointed out, the origin of cancers is comprised in a direct insufficiency of the nervous system at a determinate point of the economy. At this point soon appear unexpected disorganised cells, wretched waifs that offer a power of resistance absolutely incapable of withstanding the electrical effluves. These last without delay eliminate the neoplasm and at the same time re-establish the nervous influx and the physiological action of the neurons. I may here remark that the elimination is very much more rapid when the cells are denuded, so that the dynamic penetration can operate directly on the very elements of the tumour. The cancer cell is a young cell (even embryonic), containing within itself an inexhausted reserve of the power of evolution. In my thesis (Paris, 1884) I spoke of the force accumulated and condensed in the generative cell, and of the evolutionary force associated with the material (for me the state of condensation of power). Hallion has cleverly put forward the very likely hypothesis that with regard to cancer we have to deal with a cell rejuvenated by abnormal fecundation, and not with a cell that has remained young and that has taken on again (by reason of any application of vis a tergo) an evolution which for a long period had been interrupted. This is the karyogamic theory, a rational hypothesis of renovation by conjugation or copulation of fertilising nuclei. This theory explains the injudicious and ill-timed effort taken on by a species of cell held in "subjection" to try to regenerate itself in the same manner as a species of cell which is autonomous or "free." For this reason the neoplastic cell is much weakened in its resistance. It conducts itself as a veritable pathological sperm, a promoter of tumours, inasmuch as this aptitude of conjugation, this karyokinetic particularity, are pathognomonic of malignant tumours. Unconfined and absolutely freed as to its direction, thrown out, as it were, the cell becomes the founder of a liberated tribe which renounces, so to speak, all social compact and ignores its previous obligations with regard to the organism. Therefore, as the nervous system no longer directs it, naturally it has a tendency to exhaustion and atrophy (such is the ephemeral existence of protists). All this I have said before, more than twenty years ago, in my works on nevrarchy and nervism.

The ingenious karyogamic theory (supported by Maupas, Fabre-Domergue, and Hallion) explains to us the rarity of cancer at very advanced age, and the pretty frequent etiological rôle played by traumatism, and especially by frequent irritation, in the ordinary proliferation of malignant tumours. By disturbing elementary nutrition we always realise these conditions of imperfect alimentation which, according to Maupas, favour cellular conjugation in the infusoria. I will add that uric acid should also be taken into consideration as a cause of permanent irritation in anatomical elements. It is for this reason that arthritic subjects furnish every day so important a tribute to carcinosis. It is also for this reason that this terrible diathesis presents a development parallel to the curve of the consumption of meat and of fermented or distilled drinks (vegetarians and abstemious people in a large proportion escape the visitation of cancer). High-frequency currents, by preventing the precipitation of urates, by favouring elimination and complete combustion of nitrogenous matter, cut off, as it were, the supplies to the cancerous process, thus preventing the organic cells from taking on karyogamic proliferation, the great abettor of neoplasms and of the most serious neo-organisms.

Conclusions.

(1) It has always seemed to me that high-frequency currents, in the form of effluves or of mono- or bi-polar sparks, enjoy the property of having the most trustworthy, the most continuous, and the most penetrating, modifying action on neoplasms. This observation is the result of experiments and researches lasting over ten years, and my rights of priority in this respect go back to my communication to the Congress of Medical Electrolysis and Radiology (Paris, July 27th, 1900), and to my communication to the Academy of Medicine in 1903.

(2) Nevertheless, one must not be exclusive, and it is our duty to judiciously utilise against neoplasms all the practical agents contained in the physico-therapeutic armamentarium. Röntgen rays, actinism, sparks and currents of static electricity, radium (a), ultra-violet rays, ionisation, electrolysis, etc., etc., all furnish valuable and often indispensable help in hastening the cure either by destroying the neoplastic masses, or by strengthening the neurons, or by impelling the neoplastic particles destroyed and carried away by the stream of the circulation to take on the necessary elimination, or finally by bringing back the vital processes to the normal.

(3) The power of the big bi-polar effluves or of the high-frequency sparks is especially more penetrating and more efficacious in the treatment of deep tumours. It is this power that foils with the greatest vigour the whole histogenesis of malignant tumours, and this without the slightest possible suspicion of inflammatory reaction, inasmuch as violet irradiation contains no calorific ray.

(4) It is the karyogamic theory of Hallion (disordered liberation of the cells and fecundation of the embryogenic elements) that best explains the reason my treatment invariably respects the vitality of healthy tissues, and at the same time possesses a kind of elective affinity for the constitutive elements of the neoplasm.

(5) Malignant tumours from their commencement, recurrent tumours and those considered inoperable, are amenable to physico-therapy.

(6) As in 1900 and 1903, I still persist in asserting that large tumours should be removed by the bistoury and treated afterwards by my method to prevent recurrence, and to cure a recurrence should it take place.

(7) Effluvation and the projection of high-frequency sparks should follow all surgical operations on malignant tumours.

(8) With the object of preventing recurrence after cicatrisation, a few currents applied periodically, then after intervals whose lengths should be decided by a medical man, seem to me of paramount necessity.

(9) Physico-therapy, which is the rational method to employ against malignant tumours, constitutes also for them a line of preventive therapeutics.

GASTROJEJUNOSTOMY AND REGURGITANT VOMITING. (b)

By K. W. MONSARRAT, M.B., F.R.C.S.E.,

Surgeon to the Northern Hospital, Liverpool; Lecturer on Clinical Surgery, University of Liverpool.

It is well known that in a certain number of cases of anterior gastrojejunostomy, and in a lesser number of cases of the posterior operation, the result has proved disappointing owing to the regurgitation of the contents of the duodenum into the stomach. If this co-called vicious circle is established, persistent and exhausting vomiting occurs, and in some instances this has proved the direct cause of death.

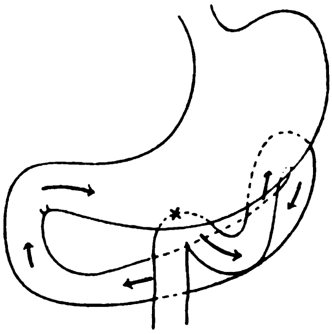
It has been experimentally shown that the mere entrance of bile and pancreatic fluid into the stomach is not capable, in itself, of inducing this complication. It may conceivably arise from one of four mechanical defects left by the operation.

(a) With reference to Radium, it is with much pleasure that I recall a conversation I had with my distinguished colleague, A. Darier, on the occasion of his visiting me in August, 1903, to express his astonishment on finding, when he returned from his holidays, that a patient, who had suffered from generalised lympho-sarcoma, whom he had confided to my care *in extremis* three weeks before, and who had been irremediably condemned by him and by several other medical men, was absolutely cured. I then told him, word for word, that he had before his eyes the result of a combined action of Rontgen rays and high frequency effluves and sparks, that in 1900 I had spoken of the action of the actinic rays, and that, in my opinion, Radium together with actinic and Rontgen rays must have an absolutely certain and positive action on cancer. We went out together to buy some Radium. A little while afterwards, in a very important paper he read to the Academy of Medicine (reported by M. Cornil), he related the case of this patient I had cured by extensive high frequency effluves and sparks and the Rontgen rays, and he seized upon this occasion to speak of the action of Radium on Cancer.

(b) Paper read before the Liverpool Medical Institution.

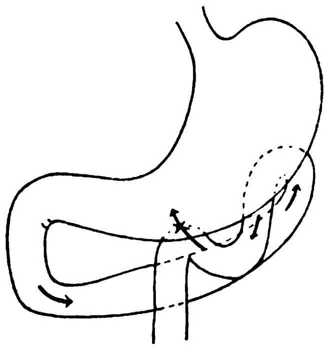
In the first place, the duodenum may empty itself backwards through the pylorus owing to a mechanical obstruction at the point of anastomosis; this is probably the state of affairs in the majority of the cases. Secondly, the duodenal contents may, instead of passing on from afferent loop to afferent loop, empty themselves back into the stomach through the artificial opening. Such an event can only happen, as in the first class, if there is some obstruction preventing the free passage from afferent to efferent loop. Thirdly, the parts may be left in such a situation that the stomach empties itself in the direction of the afferent loop instead of forwards into the efferent branch. Fourthly, an obstruction of the efferent branch may arise, causing it to empty itself backwards into the stomach.

These four types are illustrated in the accompanying diagrams.



It is true that fatal cases have been described by surgeons in which the post-mortem examination showed none of these defects in the mechanical arrangements left by the operation. Still, no other explanations of such cases have been offered, and it is possible that a post-mortem examination might not clearly reveal a sagging afferent loop and an acute bend at the anastomosis which had been present during life to a degree sufficient to cause the complication.

Assuming that in all cases of regurgitant vomiting the explanation is to be found in one or other of these mechanical defects, the method of performing the anastomisis must be so devised that the possibility of their occurrence is avoided.



The characteristics of a satisfactory anastomosis are—

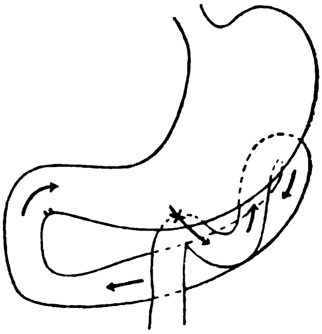
(*a*) An opening large enough to anticipate a certain amount of contraction. The incisions in the stomach and jejunal walls should be not less than two inches in length, and an ellipse of mucous membrane should be removed according to Moynihan's recommendation.

(*b*) A situation at the most dependent point near to the greater curvature of the stomach.

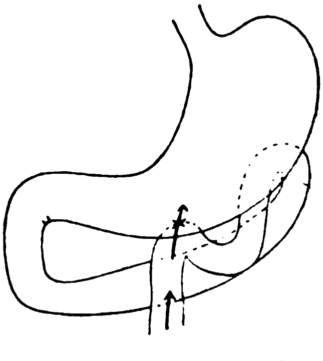
(*c*) A free and unobstructed passage from afferent to efferent loop, and from stomach to efferent loop.

For the avoidance of regurgitant vomiting the third characteristic is all-important, and a whole series of operations have been devised to provide it. (*a*) Kocher's valvular gastroenterostomy is particularly designed to ensure a passage of stomach contents into the efferent loop, and to prevent their passage into the afferent loop. (*b*) The Y-anastomosis of Roux has as its object the certain prevention of the passage of duodenal contents into the stomach through the anastomotic opening. (*c*) The combination of entero-anastomosis with gastrojejunostomy aims at anticipating any obstruction to the passage of the contents of the afferent loop onwards into the efferent loop.

Kocher's method alone without other precautions does not deal with the most common cause of regurgitation, viz., obstruction of the afferent loop at the point of anastomosis. The two other methods mentioned have the disadvantage that they are double anastomoses, and therefore add somewhat to the risk and to the length of the operation.



Petersen was the first to draw attention to a point in the performance of posterior gastroenterostomy which promised to prevent obstruction of the afferent loop at the anastomosis, and therefore to avoid the commonest cause of regurgitant vomiting. He pointed out that the posterior surface of the stomach near the greater curvature and the jejunum near its commencement are, under circumstances of moderate gastric distension, in close relationship with one another, and that these points of normal apposition should be chosen for the anastomosis. The importance of this suggestion has been appreciated by other surgeons. Several advantages follow the establishment of the anastomosis at the point indicated.



In the first place, when the operation is complete there can be no sagging afferent loop to cause a kink at the junction, as, when the parts are returned to the abdomen, the jejunum simply descends from duodeno-jejunal flexure to anastomosis in what is practically a straight line. Secondly, there will be no tendency for stomach contents to collect in the afferent branch; they would have to ascend against gravity to do so.

The results of operation planned on these lines have fulfilled anticipations: It would not be true to speak of regurgitant vomiting as a thing of the past, but now that the anterior operation has been almost abandoned and the posterior operation is carried out in the manner described, it is rarely heard of. During the past year I have paid particular attention to the points in technique which I have mentioned, and though the number of cases in which I have thought gastrojejunostomy indicated is small, I think them worth recording owing to the entirely uneventful course which they have all followed.

Case 2 is of special interest from the point of view of the diagnosis of malignant disease.

1. James R., æt. 29, complaining of epigastric pain and frequent vomiting for about two years, during the greater part of which he had been under medical treatment. He was in a medical ward for a short time before he was transferred, his chief symptom being vomiting of very large quantities of sour-smelling grumous fluid containing lactic and butyric acids and sarcinæ. He was treated by gastric lavage with temporary relief. On examination, the stomach was found dilated so that its lower border reached midway between the umbilicus and pubis; no epigastric tumour was to be felt. Gastroenterostomy was performed on October 4th. There was mechanical obstruction at the pylorus in the form of a thickened indurated area narrowing the channel, evidently a stenosis due to ulcer. He vomited once immediately after the anæsthesia, but not again, and was discharged well on October 30th. He was seen on October 11th, 1906, a year after the operation. He had put on 28 lbs. in weight; the lower border of the stomach was 1½ inch above the umbilicus; he had vomited once or twice during the year, but had had no other gastric troubles.

2. Bridget N., æt. 44. Transferred to my care by my colleague, Dr. Warrington. She had been subject to flatulence and heartburn for a long period, had been vomiting frequently for four months, and had intense epigastric pain. There had been hæmatemesis and also melæna, and she had lost much flesh. On examination, a hard mass was to be felt in the epigastrium about the size of a small orange; forcible peristaltic movements could be seen passing from left to right over the stomach. No free hydrochloric acid was found after a test meal. In the vomited matter there were no sarcinæ, but organic acids were present equal to a total acidity of 50 c.c. decinormal sodium hydrate.

At the operation a large crater-like ulcer was felt on the posterior wall of the stomach at the pylorus; it was adherent posteriorly, where it was surrounded by a hard indurated mass. Posterior gastrojejunostomy was performed. She vomited on the night of the operation, and the following day, and once on the fifth day, but otherwise her convalescence was smooth. She left hospital four weeks after the operation. Seen on October 20th, 1906, seven months after the operation; no abdominal tumour was palpable, she had put on weight considerably, and had no gastric pain or other symptoms. This after-history points to the fact that the epigastric tumour was of an inflammatory nature, although the clinical signs before operation all seemed to point to malignancy. After the operation the perigastritis subsided, and apparently the ulcer healed.

3. Elizabeth M., aged 49. Transferred to me by my colleague, Dr. Bushby. I had previously operated on her for symptoms referable to a movable kidney. There was marked dilatation of the stomach, with splashing and vomiting; the greater curvature reached within three fingers' breadth of the symphysis pubis. There was a distinct hysterical element in the case, which made me hesitate to operate for some time, as the final results in such cases are notoriously uncertain. The point that decided the question was the absence of hydrochloric acid in test-meal experiments. Posterior gastrojejunostomy on July 23rd. The stomach was thoroughly examined, but no lesion suggestive of malignant disease was found. She vomited immediately after the anæsthetic, and once on the eight day after operation, not otherwise. She left hospital seventeen days after operation. Seen four months after operation, she had put on flesh; she still had various complaints in different parts of her anatomy, but her gastric symptoms were at any rate much improved.

4. Thomas C., æt. 43. Sent to me by my colleague, Dr. Warrington. Gastric symptoms for about three years. Pain relieved by food. Had had hæmatemesis on two occasions, and he says also that the motions have often been black. He had lost 4 stone in weight during the previous four months. The stomach extended to half an inch below the umbilicus; frequent forcible and painful contractions of the stomach wall were a marked feature of the case. Hydrochloric acid was present. Operation on July 18th. Duodenal stricture was found, due to cicatrisation of an ulcer. Posterior gastrojejunostomy was performed. There was no vomiting after the anæsthetic or subsequently; previously this had been going on every day. He left hospital twenty-two days after operation in good condition. He has been seen subsequently as an out-patient several times; he put on flesh rapidly, and had no further pain or vomiting.

5. William K., æt. 27. Under medical treatment for eight months for cramp-like pains in the stomach, coming on from half an hour to an hour after food. He improved temporarily, but relapsed whenever treatment was suspended. On examination he presented a marked and localised tenderness just inside the tip of the right costal cartilage; no blood was detected in the stools, but patient described melæna on several occasions. The history and signs pointed to duodenal ulcer. The abdomen was opened on September 26th, and a firm indurated area about the size of a florin, evidently an ulcer, was found in the duodenum close to the pylorus. Posterior gastrojejunostomy was performed. The man vomited once on his return to the ward, not subsequently. His convalescence was retarded by a smart attack of broncho-pneumonia. He left hospital in good condition twenty-four days after the operation. I saw him on November 17th; he had had no further gastric symptoms.

These cases show what an uneventful and even course may be expected when posterior gastrojejunostomy is performed in the manner I have described. Simple suture by means of an inner continuous layer taking up all coats, and an outer continuous layer taking up serous and muscular coats, is the technique to be preferred. Clamps are used for the stomach and the jejunum.

One point has struck me in regard to these and other cases of definite gastric and duodenal ulcer, and that is that in every case the power of mastication has been practically absent owing to wretched teeth. The first step in the treatment of gastric ulcer is to remedy the condition of the mouth. If this is true, physicians and surgeons need not quarrel over the treatment of gastric ulcer in its early stages; it belongs to neither of them, but to the dentist.

OUT-PATIENTS' ROOM.

CHILDREN'S HOSPITAL, PADDINGTON.

Inguinal Hernia in an Infant.—A Simple Truss.

By Arthur Edmunds, M.S., F.R.C.S.

Amongst the out-patients was a male child, æt. 9 months, who was suffering from ordinary oblique inguinal hernia. The swelling was about the size of a walnut, was readily reduced, but reappeared when the child cried or made any other straining effort. The penis was well formed, and the foreskin, although a little long, presented no obstacle to micturition. The child was in all other respects normal; the bowels acted freely and regularly; the appetite was good, and the boy did not cry to any extent except when the hernia was down, when he seemed to experience a certain amount of abdominal pain. The child slept well, the hernia always reducing itself spontaneously during sleep. Mr. Edmunds remarked that these cases are extremely common, several of them being brought for treatment at every out-patient clinique, and their treatment was correspondingly important. For a long time it was taught that operative interference in these cases should be deferred until the child had acquired conscious control over the bladder and rectum, but more recently operations have been undertaken in large numbers and with complete success on these cases. Postponement of the operation is, he said, often disappointing, a child which before had complete control passing his evacuations without any notice after the operation. This, however, is not a matter of such very great moment, inasmuch as it is possible to perform these operations by making the incision rather high up, so that soiling with fæces can be completely avoided. The urine, however, is very likely to soil the dressing, but if the case be carefully watched, and the dressing changed whenever this occurs, disaster is very infrequent. Stiles has attempted to overcome this difficulty by dispensing with a dressing entirely. After the wound has been sutured, it is carefully dried and powdered with boracic acid; a low cradle is then placed over the child, and covered with an old blanket, so arranged that it is only a very short distance above the meatus. The child passes his water directly into this blanket, which is changed as often as necessary. This method is very successful, the resistance to sepsis in a child being sufficient in most cases to overcome the small amount of infection which is introduced through the wound after operation. In this hospital an objection to this type of treatment is the small number of beds at the disposal of the surgeon, so that attempts have to be made to treat these cases as out-patients as far as possible, and this is undertaken with very considerable success. It must be remembered that hernia of this description is produced, not so much by a definite pathological process, as by a delay in the normal physiological one—that is to say, the funicular process remaining unobliterated after birth, so that it is reasonable to hope that if distension of the sac of the peritoneum can be prevented, obliteration will follow in due course. Trusses for children of this age are usually made of india-rubber, a material which can be readily washed, but none the less becomes sodden with urine. As a substitute for this, a skein of wool is extensively used, but it is not very efficient. The best method consists in taking a strip of soft flannel a yard and a half long, and an inch and a half wide. This is folded in two, the folded portion being placed over the neck of the sac, the two tails carried round the pelvis, and ultimately threaded through the loop from above downwards, so as to encircle the body with a noose of flannel. The two ends are then passed under the leg on the affected side and stitched to the belt of flannel at above the level of the posterior superior iliac spine. Attention is now paid to the point where the two tails pass through the loop; there is tendency for the knot produced in this way to wrinkle up, and this must be prevented by spreading out the loop and by stitching its upper corner. In this way a ridge is formed across the inguinal canal, which prevents the hernia from coming down without exercising undue pressure on the delicate structures in this region. Sometimes this truss has a tendency to slip down, and it must then be supported by a shoulder-strap passed across the opposite shoulder. Sometimes there is a little chafing round the groin, but this is usually easily overcome by using a little vaseline. The child is bathed with the truss on, a fresh one being prepared for use after the bath. This treatment must be continued for about 12 months, at the end of which the hernia will usually be found to be permanently cured. This mode of treatment fails in large hernias and in children over 18 months, but for suitable cases it is a cheap and efficient method.

OPERATING THEATRES.

WESTMINSTER HOSPITAL.

Removal of the Rectum and Part of the Sigmoid by the Perineal Route.—Mr. Tubby operated on a woman, æt. 44, who had been admitted suffering from symptoms of intermittent constipation, and a muco-sanguineous discharge from the bowel. She was fairly well nourished, but had a prematurely aged look. The abdomen was moderately distended, particularly in the flanks; she was somewhat tympanitic, but her condition was by no means acute. On examining the rectum, its lower part was found to be distended, but with the finger no sign of growth could be felt, although it was strongly suspected that such was present. Ten days after admission an exploratory operation was carried out, and in the pelvis there could be distinctly felt an irregular hard tumour occupying the lower part of the sigmoid flexure and slightly encroaching on the first piece of the rectum. It was decided to perform an inguinal colotomy, which was accordingly done, the bowel being opened on the second day after the operation. Fæcal matter passed regularly from the colotomy wound, the patient became more comfortable, and her appearance was less emaciated. The question had now to be faced of the best method of dealing with the growth, and naturally the combined or abdomino-perineal method suggested itself. It was, however, finally decided to attack the bowel from the perineum, and, if undue difficulty was encountered to perform an abdominal section and liberate the growth from above. For the past ten days the lower part of the bowel had been washed out through the colotomy wound with boracic acid solution. Fortunately no fæcal matter had passed below the artificial anus, and the boracic acid solution issued from the natural anus slightly stained of a dark brown colour, which originated from breaking down of the growth. With the aid of Messrs. Carling and Swainson excision of the growth was undertaken by Mr. Tubby; it was hoped to preserve the lower part of the rectum with the sphincters, and to be able to draw down a portion of the sigmoid and unite it to the lower part of the rectum. The patient was placed in the lithotomy position with the buttocks well elevated, and good artificial light was provided. An incision was then made from just behind the sphincter ani, then along the median line to the middle of the sacrum. The tissues were rapidly retracted, and the coccyx removed. The levator ani on both sides was detached from the rectum. The finger was then passed up along the hollow of the sacrum, and the bowel detached as high as the sacral promontory. The bowel was also separated laterally and anteriorly from the vagina. It was easy to identify the bowel as it was packed with iodoform gauze. All hæmorrhage having been arrested and the vessels tied, the peritoneum was opened on the right side, then in front of the rectum, then on the left. The growth could now be palpated freely, but at first could only be brought down with difficulty. It was found to have increased greatly in size since the preliminary operation. The main difficulty consisted in the shortness of the meso-rectum and the induration of the lower part of the meso-sigmoid; however, after considerable trouble and very careful detachment of the parts with the finger and forceps, the growth was brought well down and partially outside the wound so that a ligature could be placed rather more than an inch above the tumour. It was found more convenient to begin the removal of the rectum from below; this was accordingly divided between two ligatures about two inches above the anus. The remainder of the rectum, together with the lower part of the sigmoid below the upper ligatures, was then carefully shelled out; it was found to be possible to draw healthy sigmoid down to the remainder of the rectum and join it by a continuous suture. The patient suffered much from shock, as the operation was prolonged, but, happily, Mr. Tubby said, she lost very little blood. The wound was left open, and was fully stuffed with gauze. Mr. Tubby remarked that a preliminary colotomy was of great advantage in these cases, as it not only rendered the patient comfortable, but also permitted the lower part of the bowel to be washed and rendered as aseptic as possible. But it had the disadvantage of causing some difficulties in a subsequent abdominal section on account of the possibility of contamination of the wound. Despite this, in the particular case under notice, he felt that it would have been better to have performed an abdominal section, free the growth from above, and then removed it through the perineum. The shorter duration of the operation and the lessened shock to the patient more than compensated for the risk of sepsis of the abdominal wound. The removal of so large a mass through the perineal route, while showing that a very large portion of the bowel may be removed in this manner, is not, he thought, so satisfactory an operation as the combined abdomino-perineal method.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE

MEDICAL SECTION.

MEETING HELD TUESDAY, NOVEMBER 26TH, 1907.

The President, Dr. S. J. GEE, in the Chair.

Dr. **ALFRED E. RUSSELL** read a paper on the

NATURE OF EPILEPSY.

He said that the old theory that epileptic and many other convulsive attacks were explicable on the hypothesis of a sudden failure of the cerebral circulation was worthy of reconsideration. That such a failure was competent to produce unconsciousness and convulsions had been proved experimentally by several investigators, while the phenomena of Stokes-Adams disease and heart block afforded clinical evidence in the same direction. Opportunities of making observations were scanty because it was impossible to predict when a fit would occur and because the period of cardiac inhibition was of necessity very short. An attack of ordinary syncope (faint) offered both analogies and contrasts to the epileptic fit. Intermediate cases occurred in which it was difficult or impossible to make a diagnosis. The causation of cardiac inhibition in epilepsy must be sought in the marked vaso-motor and cardio-motor instability which was a feature of the disease. Dr. Russell quoted cases in which both vagal and vaso-motor symptoms were combined. The phenomena of *petit mal* were also considered. He observed that the similarity between infantile convulsions and epilepsy was very marked, and submitted that the same explanation held good for them. It was noteworthy that the cardiac and vaso-motor systems in the child were very sensitive, as seen, for instance, in the phenomena of fright. On the hypothesis of cardiac inhibition as the precipitating factor of the fit, recovery followed on the escape of the heart from inhibition. If the hypothesis were correct it should afford a satisfactory explanation of the various phases of the fit, and Dr. Russell submitted that this was the case. In regard to uræmic convulsions, experimental and clinical evidence was brought forward to show that the cerebral manifestations of uræmia might be due to a condition of increased intracranial tension with resulting cerebral anæmia. Concerning Jacksonian epilepsy, the difficulty of correlating cerebral anæmia with this condition was discussed, and evidence was submitted that cerebral anæmia existed both in status epilepticus and in the epileptiform seizures of general paralysis.

Dr. D. **FERRIER** remarked that vaso-motor regulation of the brain circulation was a small part in the consideration of the question; it had been shown that vaso-motor spasm caused flushing of the brain. He did not think there was evidence to show that vaso-constriction would cause anything but flushing. Dr. Russell would transfer the origin of epilepsy from the brain to the heart, but he (Dr. Ferrier) thought they ought to have proof of some definite relation between heart disease and epilepsy, and he did not believe that such proof existed. He quoted figures showing that out of 500 epileptics there were about 1¼ per cent. with some signs of cardiac disease, whereas in 800 cases of heart disease there was not one case of epilepsy. Epilepsy was not so much a matter of the circulation as of the nutrition of the nerve cells. He considered that the condition of the circulation was secondary to the epileptic discharge from the cortical cells.

Dr. C. E. **BEEVOR** said that experimentally by stimulation of the thumb centre it was possible to get a tonic localised contraction, but by using a stronger current it was possible to produce a fit affecting the whole body, and it was certain that in those cases there was not inhibition of the heart. In the case of fits produced by brain tumours, in which it was possible to have fits without loss of consciousness, it seemed impossible that they could be ascribed to want of action of the heart. Those brain tumours might grow and cause fits just like epilepsy, and he did not see how in such cases the heart's action could be taken into account. In regard to *petit mal*, it seemed impossible that the heart failure should have such a limited effect as to produce loss of consciousness, and yet not cause the patient to fall down. Further, attacks of *petit mal* might occur, and be combined with attacks of idiopathic epilepsy. It was difficult to think that the *petit mal* was due to one cause, and the epilepsy to another; they must be due to one cause, and that could hardly be the heart. The question was whether the primary disease was in the heart or in the cortex of the brain, and in his opinion the primary disease was in the cortex, and he did not consider that the heart was responsible in idiopathic epilepsy.

Dr. A. M. **GOSSAGE** said that if cardiac inhibition was to be regarded as the commonest cause of epileptic fits, then there ought to be more evidence of the occurrence of such inhibition than they possessed. He thought it possible that the cases brought forward by Dr. Russell might be classed with cases of Stokes-Adam syndrome.

Dr. J. **LINDSAY STEVEN** (Glasgow) doubted if enough weight had been placed on the factor of vaso-motor anæmia of the brain as a cause of cerebral disease and possibly of epileptic disease. He drew special attention to the relationship that existed between cerebral anæmia and Raynaud's disease.

After Dr. E. **FARQUHAR BUZZARD** and Dr. **BIERNACKI** had spoken, Dr. **RUSSELL** replied, and the meeting terminated.

ELECTRO-THERAPEUTICAL SECTION.

The annual conversazione and exhibition of new apparatus, heretofore held under the auspices of the late British Electro-Therapeutic Society, but now under the Electro-Therapeutical Section of the Royal Society of Medicine, will be held in the Queen's (small) Hall, on Friday, December 13th, 1907, from 7.30 p.m. to 11 p.m. The exhibition will be open from 3 p.m., and light refreshments will be provided both afternoon and evening. All the leading makers of electro-medical and

X-ray apparatus are taking part, and many new designs will be shown, as far as possible under working conditions. A noteworthy feature will be a display of X-ray tubes from the earliest to the latest patterns. Medical practitioners will be welcome on presentation of their visiting cards, as also will members of the dental profession and recognised teachers of the physical sciences. Others will be admitted on payment of a fee of 5s.

Communications regarding cards of admission or other matters must be addressed to Reginald Morton, M.D., Hon. Secretary, 22, Queen Anne Street, Cavendish Square, London, W.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, NOVEMBER 15TH, 1907.

The President, E. H. TWEEDY, M.D., in the Chair.

EXHIBITS.

DR. **ALFRED SMITH** exhibited two fibro-myomatous uteri with ovarian cyst attached. One generally associated with fibroid tumours of the uterus, he said, certain degenerations of the ovary, but he did not think he had seen—certainly not in two consecutive cases like those exhibited—ovarian cystomas associated with fibroid tumour.

The **PRESIDENT** said there was no reason why a cyst should not grow in a woman who was already afflicted with myoma, yet he did not remember ever having seen them attached before.

Dr. **PUREFOY** said that a few weeks ago he had removed a dermoid cyst, with which was associated a fibroid uterus.

On the suggestion of Dr. **ROWLETTE**, one of the tumours exhibited by Dr. Alfred Smith was opened, and proved to be a dermoid cyst.

Sir A. V. **MACAN** exhibited a case of uterine carcinoma and double ovarian cystoma. He said the woman was 45 years of age, had been married since she was 15, but had had no children. The catamenia were still regular, and, except for violent hæmorrhages, the patient complained of nothing. On opening the abdomen an ovarian tumour was found and removed, and, to his surprise, he then found another. The uterus was then extirpated. Afterwards the patient got bronchitis, which gave him some anxiety, and later, out of one of the stitches, fluid stuff came like the contents of a dermoid cyst. However, she made a good recovery.

The **PRESIDENT** thought it was rather fortunate for a woman who was suffering from carcinoma to get an ovarian cyst, as it might cause the diagnosis of carcinoma to be made all the earlier.

Sir A. V. **MACAN**, replying to a question by the President, said the patient was first curetted to make the diagnosis, and it being determined that it was carcinoma of the uterus, it came to be a question of extirpation by the vagina or the abdominal route.

Sir **WILLIAM SMYLY** exhibited a case of sarcoma of the uterus (?), and regretted the note of interrogation, but it was difficult to say what organ the tumour really sprang from. On October 21st he had seen the patient for the first time. She was feverish, and looked very ill. On making a bi-manual examination, he found a myomatous uterus, and also a detached tumour in the abdomen. When admitted afterwards to hospital she had all the symptoms of septic fever. It was quite evident that one of the tumours was suppurating or sloughing, and that she could not live any length of time in her then condition. As a desperate resource he determined to try to extirpate the source of infection. It was generally admitted that it was better to remove a septic tumour by the vagina, as it was less likely to cause a general peritonitis or a hernia than removal by the abdominal route. The woman was unmarried, and had a narrow vagina, which presented the ordinary difficulties. After a good deal of labour morcellating the uterus he got it outside the vulva. It had been held by the tumour above, which had prevented it from coming down. To get the tumour he had, after all, to open the abdomen, and he found everything matted together. He separated the adhesions, scooped out the sloughing *débris*, and left a cavity with ragged, infiltrated walls communicating with the lumen of the gut by an opening as large as a sixpence. It was evident that the malignant disease had extended from the tumour through the walls of the intestines, and it had involved so many of the coils of intestines that he now reached the climax of his woes, and found it impossible to remove the disease. In the desperate circumstances he stitched the intestines round the cavity as well as he could, and the woman had not exhibited any bad symptoms up to that day, which was the fourteenth from the operation.

Dr. **HARVEY** confirmed Sir William Smyly's remarks as to the difficulty of saying what the tumour really was. Histologically it was mixed-celled sarcoma.

PRESIDENT'S ADDRESS.

Dr. **HASTINGS TWEEDY**, in thanking the section for electing him their President, said that the position had been held in the past by men who had made the Obstetric School of Dublin famous, and that it was through the Royal Academy of Medicine in Ireland that the profession in Dublin have the opportunity of making known to their countrymen and to the world at large that their work is worthy of more than provincial fame. He complained that the section had not of late years received the support it deserved, and it lacked the vitality of the past. This slackening of interest dated from about the beginning of the Boer War, and in his opinion might be attributed to it. The war had a most disturbing influence on men's minds, and during a period of almost daily disaster the members of this section had no heart to attend the meetings; thus habits were formed of which the influence is still felt. Of other explanations, the most plausible is that which suggests that gynæcology has ceased in its power to interest, and that as an art it has made no appreciable advance within the last decade. In combating this view he dealt with the radical changes which have been effected within the past four years. Rubber gloves are now universally worn not alone in abdominal but also in vaginal operations. The rinsing the cleansed hand in methylated spirit, and the partially filling the gloves with similar fluid, enables them to be readily slipped on, and secures an almost aseptic condition of their contained fluid contents, even after they have been worn during a two-hours' operation; thus injury to the glove is not fraught with fear of septic infection through oozing of its fluid contents. We now dispense with much of the elaborate ritual formerly considered necessary in hand-washing. Skin maceration in the neighbourhood of the field of operation is prevented by painting the surface over with a saturated solution of picric acid in spirit. This solution is also of great use when applied to papillary erosions of the less chronic type.

VAGINAL SURGERY.

In vaginal surgery the field of operation has been rendered more sterile by the clipping of a strip of boiled Billroth tissue across the perinæum to shut off the anal region, whilst the bags which enclose the legs are now connected with an abdominal apron which prevents the operator's hands being contaminated in the event of his having to pause in the midst of an operation to make a bi-manual examination. The large semilunar incision of Strasseman provides a rapid and ready method of separating the bladder from the cervix, and performing extensive operations through this route. For vaginal fixation the older T-shaped incision is to be preferred, but here again an improved technique is adopted in that the peritoneum is now insinuated between the vaginal wall and the fixing sutures of the uterus. The technique for the cure of cystoceles and rectoceles has been much improved—in the former by tucking up the bladder and rolling it inwards on itself with fixing catgut sutures, and in the latter by joining again the fibres of the levator muscle and pelvic fascia. The vaginal operation for cancer of the uterus is much more extensive than formerly. Pus tubes are dealt with in a way that almost ensures a safe recovery. If very acute the abscess can be opened by entering the abdomen through the posterior fornix, and directly draining through this hole. If a relapse takes place the pus is rendered less septic, and the case may be considered alone amenable to the more radical operative procedures. In this eventuality he strongly advised the splitting of the uterus in two halves, the insertion of the whole hand into the abdominal cavity, the breaking down of adhesions, and the forcible dragging out of the diseased tube with its attached half of the uterus, the clamping of the tubes outside the vulva, the pushing the clamps into the abdomen, and the insertion of iodoform gauze between them (Landau's operation). Atmocausis has enabled many hæmorrhagic cases to be cured that formerly would have required removal of the uterus. Through the abdominal route pus tubes can be removed with greater safety than formerly by the plan of splitting the uterus down the centre and removing them together with that organ. Tubes affected with interstitial salpingitis are re-sected, and their lumens made patent. Ovaries are freely resected rather than sacrificed. Raw surfaces are covered over with peritoneum. It is now a matter of indifference (so far as the primary operation is concerned) as to whether the uterus is removed with or without its cervix. Both operations have become easy and safe in their performance, whilst unpleasant after-symptoms have been obviated by the non-removal of the ovaries. In spite of this advantage the operation is less often done than formerly, because of the advantages offered by myomectomy as now performed. The uterus can be split in halves, the myomas enucleated from its walls, and the organ again stitched up after the manner which obtains in Cæsarean section. Operative treatment for cancer of the uterus has been revolutionised. Formerly, if the organ was fixed, it could not be readily pulled down, or had its cervix badly eroded, surgical relief was unobtainable. It is pleasant to contemplate that gynæcologists are no longer deterred from relieving the suffering woman, even though prolonged immunity from the disease cannot be promised. The three-layer method of suturing the abdomen has made it possible to operate without any fear of a subsequent hernial formation, and the sub-cuticular skin suture threaded through a leaden plate placed on the wound throughout its entire length has made scar deformity a negligible factor. Anti-streptococcus serum (Polyvalent variety), if administered in suspected cases before symptoms have developed, provides a prophylactic agent against many forms of sepsis. Fowler's position, too, is employed from the first in these cases, and Mr. Moynihan's enthusiastic advocacy of continuous rectal irrigation on the appearance of the earliest symptoms of abdominal sepsis has in all likelihood placed in our hands another valuable therapeutic agent. The President concluded by expressing the hope that he had shown that gynæcology had not stood still, but that its advance had been as great in recent years as throughout any period of its existence.

Dr. A. N. **Holmes** exhibited cases of (*a*) carcinoma of ovary, and (*b*) cystoma of ovary, both from patients, æt. 48, and in both of whom great difficulty was experienced in getting into the abdomen. Both patients had also made a good recovery. In the first case the woman's last pregnancy had been a year previously, and after it the menses had ceased. In the second case the woman had never been pregnant. The chief points of interest were that in the second case extensive adhesions had been set up without causing symptoms, while in the first case the symptoms had been coming on for three years, and it was curious that the disease had not spread further than it did.

Sir A. V. **Macan** said the cases presented more than the ordinary difficulties, and expressed his admiration of the successful results obtained.

Dr. **Purefoy** said he had been indebted to Dr. Holmes for giving him the opportunity of assisting at the cases. The nature and extent of the adhesions in the first case had impressed him fully that the disease was malignant, and he was greatly surprised when Dr. Rowlette told him it was not. It was surprising also that in the second case there should have been such continuous improvement in the woman's condition. His experience of malignant ovarian tumour had been that recurrence, ending fatally, took place within a few months.

Dr. **Rowlette** said that, as far as could be made out from the clinical history of the case of carcinoma, it was a case of primary carcinoma of the ovary, which was said to be a rare disease. That, however, was not the experience of the Dublin Gynæcological School. The pathology of the tumour was what was usual. It consisted of large cells without any special arrangement in glandular formation. Looking at the first case with the naked eye, one would take it to be malignant, but there was some twisting of the pedicle, which led to great congestion and had been the cause of the inflammation which resulted in the adhesions. He could not offer any suggestion as to the cause of the adhesions in the other case.

Dr. **Henry Jellett** said he had seen several cases in which there was no evidence clinically of any primary infection elsewhere, and he had lately seen three cases in which there was a positive primary focus elsewhere. It was very curious that if the ovary was really the seat of the primary disease the cancer should be double.

The **President** said he was afraid that the cancerous tissue had worked itself through the adhesions, and made a permanent cure impossible—though not necessarily so.

The **President** exhibited a uterus removed by Wertheim's operation in which the amount of adjoining tissue taken away was greater than any he had ever seen. Wertheim said the ureter should not be disturbed from its bed. In at least one-third of his (Dr. Tweedy's) cases the cancer had got below the ureter, which had to be lifted in order to dig the cancer out. It was becoming a common thing with him to put a bullet forceps under the ureter and then to lift it up with the forceps while he took away the cellular tissue beneath. He had frequently had the ureter lying out of its bed through its whole extent, and yet he had never had a leakage or a fistula, which showed that there was a great deal too much respect paid to the ureter.

The following card specimens were shown:—

(1) The **President**—(*a*) Adeno-carcinoma of body of uterus, 2 specimens; (*b*) epithelioma of cervix uteri, 2; (*c*) carcinoma of ovary, 2; (*d*) ovarian cyst, 6; (*e*) fibro-myoma of uterus, 7.

(2) Dr. **Purefoy**—(*a*) Dermoid ovarian cyst; (*b*) uterine fibroids removed by myomectomy.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, November 21st, 1907.

The President, Mr. **Frank T. Paul**, F.R.C.S., in the Chair.

NATURAL COLOUR PHOTOGRAPHY IN DISEASES OF THE SKIN.

Dr. **Walter C. Oram** exhibited a selection of photographs in natural colour of various diseases of the skin taken by the new Lumière process, and gave a short account of the theory of the process.

Drs. **G. Stopford Taylor** and **R. W. Mackenna** gave a demonstration of colour photographs of skin diseases taken by the new Lumière process. Dr. Mackenna said that to photograph diseases affecting the skin was to put any process of colour photography to a severe test, and in this the Lumière process had not been found wanting, for it faithfully reproduced the most delicate gradations of colour with an accuracy never attained by the artist's brush. Their main difficulty had been to obtain definition. Since an adequate supply of autochrome plates had been procurable in this country, the weather conditions had been much opposed to successful photography. As a result their exposures had to be prolonged, and they had not found it possible to work with a smaller aperture than F.8. Their shortest exposure had been 48 seconds, and their longest 20 minutes, but they had great hopes that when the light improves again it would be possible to obtain photos not only perfect in colour but rich in detail. The photographs shown illustrated various forms of eczema, psoriasis, scabies, syphilitic eruptions, and tertiary ulcerations before and after treatment, lupus and tuberculosis cutis, acne vulgaris, medicinal eruptions, and sycosis. To photograph a rose ablaze with colour, or a gaudy orchid, is one thing; to get a correct colour picture of a disease whose hue varies but little from the colour of the surrounding skin is quite another matter; but the autochrome plates survive the ordeal triumphantly.

Dr. K. **Crossman** gave an account of photography in natural colours by the three-colour method. The colour screens used for producing the three negatives were demonstrated; also the three positives printed from the three negatives in their respective complementary colours. The three negatives were to be superimposed, and, if well done, this gave the correct representation of the original. The process was laborious and required a great deal of time. A number of slides of test objects, of leprosy patients, and of microphotographs were shown.

NOTIFICATION OF BIRTHS ACT, 1907.

Dr. E. W. **Hope** read a note on the objects of the above Act of Parliament. A declining birth-rate and a high infant mortality had led to various legislative measures designed to lessen the loss of infant life. The Act in question would enable help and guidance to be given to poor women at an earlier period of the infant's existence than was possible now, and it was hoped that such assistance may lessen the mortality during the earlier weeks and months of life which occurred to so great an extent in Liverpool and elsewhere. The obligations upon the medical man were not arduous, but it was hoped that in every case in which a medical man was in attendance the fact would be stated upon the form for notification, and in these cases no visit would be paid by the officer of the Health Committee unless it was specially asked for. Out of the 24,000 births which took place annually in Liverpool, it was estimated that 15,000 were attended by midwives, nearly all of whom were well trained and fully qualified.

Dr. **Albert Davis**, C.C., was opposed to the adoption of the Bill on the ground that notification involved a breach of professional confidence.

Sir **James Barr** moved the following resolution:—"In the opinion of this meeting of the members of the Liverpool Medical Institution, the Notification of Births Act, 1907, should be adopted by the County Borough of Liverpool."

Dr. **William Carter** seconded the resolution, and said that everyone should support to the utmost Dr. Hope in his effort to check the waste of infant life in Liverpool. The startling fact that, of the total number of deaths (4,137) under one year of age last year, 1,057, or more than a quarter, took place in the first month of life, showed the importance of early information being given, so that skilled members of the female sanitary staff might visit the mothers, who were often very ignorant of the duties of motherhood, and, when necessary, give them kindly instruction in the way to rear their infants. "Why," he asked, "should it be a breach of confidence on the part of the doctor to state within 36 hours after birth a fact which must of necessity be known six weeks after it?"

Dr. A. **Stookes** and Dr. J. R. **Logan** having spoken in its favour, the resolution was carried with two dissentients.

A CASE OF PARAPLEGIA TREATED BY OPERATION.

Dr. W. B. **Warrington** and Mr. K. W. **Monsarrat** showed a patient who suffered from paraplegia due to an intra-medullary lesion, and who had been treated with some success by the removal of a local accumulation of fluid. The patient, a young man, was able to walk across the floor of the lecture theatre with the aid of crutches.

Mr. R. W. **Murray**, Dr. F. J. S. **Heaney**, and Dr. **Stansfield** discussed the case.

Mr. **Rushton Parker** showed two patients in whom he had obtained union of previously un-united fractures of the humerus by means of implantation of bone.

CENTRAL MIDWIVES' BOARD.

A meeting of this Board was held on Thursday last, at which matter of importance to medical men was discussed. We regret that, owing to great pressure on our space, our report, which is in type, had to be held over until our next.

GENERAL MEDICAL COUNCIL.

EIGHTY-SIXTH SESSION.

First Day, Tuesday, November 26th, 1907.

Dr. MacAlister, President, in the Chair.

The **President** delivered the following address:—

Gentlemen,—Although in no fewer than eight cases the tenure of office of members of the Council has expired during the recess, in every instance the outgoing member has been re-elected; and I have thus the satisfaction of reporting that the composition of the Council is unchanged. [The eight re-elected members are:—Dr. P. H. Pye-Smith, University of London (one year); Mr. A. H. Young, Victoria University of Manchester (one year); Dr. A. G. Barrs, University of Sheffield (three years); Sir J. W. Moore, R.C.P., Ireland (one year); Dr. F. G. Adye-Curran, A.H., Dublin (one year); Sir C. L. Nixon, Royal University of Ireland (five years); Dr. D. C. McVail, Crown Representative, Scotland (five years); Dr. J. Little, Crown Representative, Ireland (five years).] I may be pardoned for noting that, for the first time in our history, we are able to count a Lord Mayor among our colleagues, Dr. Caton, who has, by the suffrages of his fellow-citizens, been raised to the chief magistracy of the city of Liverpool.

The petition and draft supplementary charter for the erection of a medical faculty in the University of Wales were submitted to you last year, and it was agreed that no objection should be taken to the grant proposed. A provisional committee of advice, to be called the Medical Board, is to be instituted, whose duty it will be to make to the University Court recommendations and reports on all matters concerning the faculty of medicine. The statutes provide that one member of this Board shall be appointed by the President of the General Medical Council.

It is clearly intended that the new degrees shall represent a high standard of general and professional attainment. It is, of course, understood that, without further legislation, these degrees will not admit their holders to the privileges of registration; nor will the University which confers them be entitled to representation on this Council. But it cannot be doubted that proposals for such legislation will ere long be made, and that you will in due course be required to express an opinion upon them.

The prospect of a further increase in our membership makes it necessary to have regard to the financial position of the Council. By the exercise of economy of time and money we have succeeded in reducing our expenditure; but our income, derived for the most part from registration fees, is not increasing, and is not likely to increase. While it is to be hoped that the efforts of the Council to improve the educational attainments of our future practitioners have not been without effect on the efficiency of those we admit to the Register, we must not ignore their inevitable tendency to reduce the number of persons duly qualified for the public service, and incidentally to diminish the available resources of the Council itself.

We may expect fresh light on these direct and indirect effects of our own action, from the laborious analysis of statistics respecting the ages and courses of study of students recently qualified, which has been undertaken by the Education Committee under the direction of its Chairman, Dr. Mackay. In pursuance of your resolution of May 30th, much valuable information on these points has been furnished by the licensing bodies during the summer. . . . One necessary advance, however, has lately been made by the Council. I refer to the new requirements in respect of training in practical midwifery. That such an advance was opportune, if it was not overdue, appears to be generally conceded by the profession. That the advance involves practical difficulties, which in certain medical centres are not easy to overcome, is also clear. . . .

Since we last met, the Bills for the protection of the public by checking the abuses incidental to the practice of medicine and of dentistry by limited companies, which were introduced by Lord Hylton in the Upper

House, have been further considered by Parliament. As you will remember, the Bills were framed under skilled advice, and received your approval as embodying real improvements on the existing law. The Medical Bill prohibited under penalties the practice of medicine or surgery by companies. The Dental Bill sought to provide that every person who under the name of a company treated or professed to treat patients, should himself be a legally qualified dentist.

The Bills, having passed the second reading without objection, were referred to a Select Committee of the House of Lords. The Medical Bill seemed to find favour with the Committee, and being reported without amendment to the House, was duly passed and sent down to the Commons. The exigencies of business, however, prevented its further progress in that House, and with many other measures it was dropped at the end of the session. The Dental Bill was strongly opposed in Committee. Witnesses representing companies of unregistered persons objected that it was unjust to restrict practices which the present Law of Companies had allowed to grow up. Others on behalf of the British Dental Association urged that the Bill did not go far enough in the direction of restriction. It allowed dental companies to exist as commercial entities, though they could only act by means of dental operators who were duly qualified. The evidence has been published, and is worthy of careful study. It illustrates at once the abuses which the Bill sought to remedy, the objections entertained by the officers of the Dental Association to anything short of the total suppression of companies in connection with dentistry, and the strength of the opposition to suppression which such companies are able to offer. In the end their lordships appeared to be influenced by the arguments of the companies rather than by those of the Association. Amendments were introduced with the object of saving for a period of years the interests which existing companies alleged; but nothing was done to make the Bill more drastic in its ultimate operation, as the officers of the Dental Association desired. Fortunately the amendments, as drafted, proved to be unworkable; and inasmuch as, apart from this defect, they seriously diminished the protection to the public which the Bill was intended to afford, it was intimated to Lord Hylton that the approval of the Council could not be held to extend to the measure in its amended form. His lordship thereupon obtained leave to withdraw the Bill, and it was not further proceeded with.

Being assured that it would be your wish, I conveyed to Lord Hylton an expression of the Council's grateful appreciation of his efforts to procure, in the public interest, a useful amendment of the law, and of his able conduct of the proceedings before the Select Committee.

The Companies Bills Committee will meet during the session to consider what steps should next be taken to give effect to the Council's instructions on the questions referred to them. . . . In the meantime certain cases have been decided in the Courts which may have an important bearing on the subject. . . . The Irish Branch of the British Dental Association has been both active and successful in the prosecution of test cases wherein these important issues have been raised, and have been settled so far as Ireland is concerned. . . . It is much to be desired that similar cases should be brought before the Courts on this side of St. George's Channel. . . .

Last May I referred in my address to certain decisions given in the Chancery Division of the High Court which touched upon the scope of your judgment of "infamous or disgraceful conduct in a professional respect," delivered in connection with an inquiry into the methods adopted by certain members of a notorious dental company. The decisions in question were subsequently reversed in the Court of Appeal, and when the cases were brought last week before the House of Lords, the reversal was sustained. The Lord Chancellor, in giving judgment, put aside as immaterial the question whether, in the circumstances of the particular action, the order made by the Council should have been admitted in evidence or excluded. But he pronounced in forcible terms, and the other Law Lords agreed with him, that the facts proved, which were those on which the Council based its judgment, did constitute "disgraceful conduct" and "professional misconduct." Thus, although the decision of the Council was not in form reviewed by the highest tribunal, the grounds of its decision were indirectly declared to be amply sufficient to justify its sentence.

The November session of the Council is in practice specially appropriated for penal business, and I regret to say that on this occasion the greater part of our time will necessarily be occupied by inquiries into cases of alleged misconduct. . . .

From information which has reached us from Canada, it appears that the provincial authorities in Quebec have agreed to a modification of the local law which assimiliates it to the provisions of Part II. of the Medical Act, 1886, and removes the difficulties in the way of medical reciprocity to which I referred in my last address. The formal notification of the change has not yet reached the Privy Council, and so we shall not be required to take any official action at this session.

In the Province of Nova Scotia, which has already begun to furnish us with applicants for home registration, legislative changes have been made which fulfil the expectations of the Executive Committee respecting the assimilation of the provincial curriculum to that which is in force at home. In other words, the recognition of Colonial diplomas by the mother country has had once more the gratifying effect of improving the conditions of medical education beyond the borders of the United Kingdom.

Moved by Dr. LITTLE, seconded by Dr. NORMAN MOORE, and carried by acclamation:—"That the President be thanked for his address, and requested to let it be printed in the minutes."

Moved by Dr. NORMAN MOORE, seconded by Mr. THOMSON, and agreed to:—"That the Council do adjourn at 4 p.m. to-day, to enable certain Committees to meet for the completion of their reports."

Moved by Dr. MCVAIL, seconded by Sir JOHN WILLIAM MOORE, and agreed to:—"That the yearly tables for 1907 be received and entered in the minutes":—(*a*) Table showing results of competition held on November 11th, 1907, for commissions in the medical staff of the Royal Navy. (*b*) Table showing results of competition held on July 25th, 1907, for commissions in the Army Medical Service. (*c*) Table showing results of competition held in July, 1907, for commissions in the Indian Medical Service.

Moved by Dr. MCVAIL, seconded by Sir JOHN WILLIAM MOORE, and agreed to:—"That the thanks of the Council be conveyed to the Director-General of the Medical Department of the Royal Navy, the Director-General of the Army Medical Service, and the Under-Secretary of State for India respectively, for the returns which they have again furnished to the Council, with the request that these returns may in the future continue to be furnished to the General Medical Council."

Moved by Dr. PYE-SMITH, seconded by Dr. MCVAIL, and agreed to:—"That the following recommendation of the Executive Committee be adopted, viz., 'That the Standing Orders, Cap. XI., 8, be amended so as to read as follows':—'The fees for attendance at meetings of the Executive Committee and the Penal Cases Committee shall be five guineas a day, and at meetings of the Branch Council two guineas a day for each member attending, his travelling and hotel expenses being also paid.'"

Moved by Dr. NORMAN MOORE, seconded by Mr. MORRIS, and agreed to:—"That the report from the Executive Committee dealing with an appeal to the Privy Council against the decision of the General Medical Council of Mr. James Wilkinson for registration under the Medical Act of Queensland which had been dismissed by the Privy Council be received and entered on the minutes."

Moved by Dr. LANGLEY BROWNE, seconded by Dr. MACMANUS:—"That this Council, deeming it to be contrary to the public interest that any person other than duly qualified practitioners in medicine and surgery should practise medicine in Great Britain and Ireland, appoint a Committee to draft such amendments of the Medical Act as may be necessary to secure this prohibition, and to report to the Council at the session in May."

Dr. Langley Browne, with the consent of his seconder and of the Council, withdrew his motion, and substituted the following:—"That a Committee be appointed to ascertain what legal provisions exist in the Colonies and Dependencies of the Empire and in foreign countries for the prevention of medical practice by other than legally qualified persons, and to consider what steps should be taken to procure effective legislation for the same purpose in the United Kingdom of Great Britain and Ireland."

Strangers by direction of the Council then withdrew in order that the Council might consider *in camerâ* certain items in the Programme of Business.

Strangers having been readmitted the President announced that the Registrar had been directed to restore the name of John Bate Bawden to the *Medical Register.*

The President further announced that the following had been appointed members of the Committee on the Prevention of Medical Practice by Unqualified Persons:—Dr. MacManus, Dr. Norman Walker, Dr. Saundby, Mr. Morris, Dr. Langley Browne, Dr. Latimer, Dr Kidd, Sir John Moore.

Moved by Dr. **Pye-Smith**, seconded by Mr. **Tomes**, and agreed to unanimously:—"That, on the recommendation of the Executive Committee, Mr. Norman C. King be appointed Assistant Secretary to the Council, at a stipend of £260 a year; and that the stipend of Mr. Storrs and of Mr. Cockington be increased to £225 a year."

Moved by Dr. **Norman Moore**, seconded by Dr. **Little**, and carried with acclamation:—"That the Council receives with regret the resignation by Dr. Pye-Smith of his office as Senior Treasurer, and expresses to him its thanks for his valuable services during the last six years."

The Council then adjourned.

Second Day, Wednesday, November 27th, 1907.

The minutes of the last meeting having been read and confirmed, the Council proceeded to the consideration of the case of John Sandilands, registered as M.B., Mast. Surg. 1888, M.D. 1894, Univ. Glasg., of the United Free Church of Scotland Mission, Bhandara, Central Provinces, India, who had been summoned to appear before the Council to answer the following charges, as formulated by the Council's solicitor:—

"That you unlawfully caused miscarriage to an orphan girl under your charge, of which offence you were on the 25th day of March, 1905, and subsequently on appeal on the 10th day of July, 1905, convicted at Bhandara, Central Provinces, India, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

Dr. Sandilands was called, but did not answer to his notice.

The Solicitor read the notice to attend, the receipt of which had been acknowledged by Dr. Sandilands.

The Solicitor also read the finding and sentence in the Magistrate's Court at Bhandara, and the judgment of the Judicial Commissioner on appeal.

Dr. Sandilands being absent this closed the case.

The Council then deliberated on the case *in camerâ*.

Strangers having been re-admitted, the President announced the decision of the Council as follows:—

That the Council have judged John Sandilands to have been guilty of infamous conduct in a professional respect and have directed the Registrar to erase from the *Medical Register* the name of John Sandilands.

The Council considered the case of Edward John Havens, registered as of East Donyland, Colchester, Mem. R. Coll. Surg. Eng. 1879, Lic. Soc. Apoth. Lond. 1879, who had been summoned to appear before the Council on the following charges:—

"That you were on November 5th, 1906, convicted of the following misdemeanour at Thorp Petty Sessions, Thorp-le-Stoken, Essex, namely, of obstructing the highway; also that you were on December 17th, 1906, convicted at the like Session of disorderly behaviour whilst drunk; and also that you were on April 8th, 1907, convicted of the following misdemeanour at Mistley Petty Session, namely, of common assault."

At the conclusion of the proceedings on May 29th, 1907, the President, addressing Mr. Havens, said:—

"Mr. Edward John Havens,—The Council have deliberated carefully on the convictions which have been proved against you, but they have adjourned the further consideration of your case till the November Session, when you should be present to hear the result of their final deliberations."

Mr. Havens attended in answer to his notice.

The Solicitor put in the notice to attend, which had been acknowledged by Mr. Havens, and read a letter from Messrs. Birkett, Ridley, and Francis, his solicitors, dated November 4th, 1907, and a letter from Mr. Havens himself, dated November 7th, 1907.

The Solicitor also reported as to the result of his inquiry concerning Mr. Havens' conduct in the interval since the last session, and read letters which he had received from the Clerk to the Magistrates.

Mr. Havens denied the accuracy of the account given by the police in regard to his conduct, and addressed the Council in his own behalf. He did not tender any evidence in support of his statements, or as to his conduct during the interval.

The Council deliberated on the case *in camerâ*.

Mr. Havens and strangers having been re-admitted, the President announced the decision of the Council as follows:—

Mr. Edward John Havens, the Council having further considered the convictions proved against you, does not direct the Registrar to erase your name from the *Medical Register.*

The Council considered the case of William Shaw, registered as of Larne, Co. Antrim, Lic. R. Coll. Phys. Edin., 1886, Lic. R. Coll. Surg. Edin., 1886, who had been summoned to appear before the Council to answer the following charges, as formulated by the Council's solicitor:—

"That you were on November 27th, 1906, convicted of the following misdemeanour at Larne Town Court, namely, of being guilty while drunk of riotous and disorderly behaviour; and on June 25th, 1907, of the following misdemeanour at Larne Petty Sessions, namely, of being found on unlicensed premises on Sunday in contravention of the provisions of the Licensing Acts; and on August 13th, 1907, at Larne Town Court aforesaid, of the following misdemeanour, namely, of being guilty while drunk of riotous and disorderly behaviour."

Mr. Shaw attended in answer to his notice, accompanied by his solicitor, Mr. W. M. Woodhouse, of Messrs. Peacock and Goddard, of Gray's Inn.

The Solicitor having read the notice, and the three certificates of conviction, Mr. Woodhouse addressed the Council on behalf of Mr. Shaw, and read letters in his favour from Mr. James Adrain, M.B. Bac. Surg., of Larne, Mr. J. W. McNinch of the Larne Cottage Hospital, Mr. Thomas Milliken, Justice of the Peace for County Antrim, and the Rev. Mr. D. H. Hanson.

He then tendered Mr. Shaw as a witness, and examined him. Mr. Shaw answered questions put to him, through the chair, by members of the Council.

The Council deliberated on the case *in camerâ*.

Mr. Shaw and strangers having been re-admitted, the President announced the decision of the Council as follows:—

Mr. William Shaw, the Council have deliberated on your case, and having carefully considered the convictions recorded against you, have not seen fit to direct the Registrar to erase your name from the *Medical Register.*

The Council considered the case of Duncan Shaw Morrison, registered as of Invergowrie, Perthshire, M.B., Mast. Surg., 1891, Univ. Edin., who had been summoned to appear before the Council to answer the following charges, as formulated by the Council's solicitor:—

"That you were on September 24th, 1906, convicted of the following crime or offence at Lochgilphead Police Court, namely, of breach of the peace, and on February 11th, 1907, at the same Court, of the same crime or offence, and on September 18th, 1907, at the same Court, of the following crime or offence, namely, of a contravention of Section 70 of the Licensing (Scotland) Act, 1903."

Mr. Morrison was called, but did not answer to his summons.

The Solicitor read the notice and the three certificates of conviction; he also read a letter which he had received from Mr. Morrison in answer to the charge.

The Council then deliberated on the case *in camerâ*.

Strangers having been re-admitted, the President announced the decision of the Council as follows:—

I have to announce that the Council have adjourned the consideration of the three convictions proved against Mr. Morrison until the May Session, 1908, when he will be required to be present.

The Council considered the cases of John P. Rafter, registered as of 338, Stanley Road, Bootle, Liverpool; Lic. Apoth. Hall, Dubl., 1882; Lic. K.Q. Coll. Phys. Irel., 1886; Lic. Midwif., 1892, R. Coll. Surg. Irel.; and John Spencer-Daniell, registered as of the Metropolitan Hospital, Kingsland Road, London, N.E.; M.B., Bac. Surg., 1906, Univ. Edin., who have been summoned to appear before the Council on the following charge:—

"That you have systematically sought to attract patients in Great Crosby and Waterloo, Lancashire, by the distribution of cards from house to house and in the street, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainants were the Medical Defence Union.

Mr. Rafter attended in answer to his notice, accompanied by his solicitor, Mr. Smith, of Messrs. James Shakespeare and Smith, of Liverpool. Mr. Spencer-Daniell also attended in answer to his notice, but was not represented by counsel or solicitor.

Dr. Bateman appeared on behalf of the Medical Defence Union, the complainants.

The Solicitor having read the notice, Dr. Bateman opened the case for the complainants.

He read correspondence which had passed between himself as Secretary of the Medical Defence Union, by whom many complaints had been received, and Mr. Rafter and Mr. Spencer-Daniell.

He then read several statutory declarations.

Mr. Smith addressed the Council on behalf of Mr. Rafter. He tendered Mr. Rafter as a witness, and examined him.

Mr. Rafter was then cross-examined by Dr. Bateman. Dr. Bateman read a letter which he had received from the Royal College of Physicians of Ireland, with reference to a complaint of a similar character which had been made against Mr. Rafter eleven years ago, concerning which he had cross-examined Mr. Rafter.

Mr. Smith re-examined Mr. Rafter, who answered questions put to him by the legal assessor, by the chair, and by members of the Council through the chair.

Mr. Smith then called Mr. Frederick Jackson, Mr. Rafter's dispenser, as a witness, and examined him.

Dr. Bateman cross-examined Mr. Jackson. Mr. Smith did not desire to re-examine Mr. Jackson, who answered questions put to him, through the chair, by members of the Council.

Dr. Bateman did not desire to address the Council again in regard to the case as it affected Mr. Spencer-Daniell, who then addressed the Council on his own behalf. He handed in a letter and testimonials which had been written on his behalf.

Dr. Bateman cross-examined Mr Spencer-Daniell, who also answered questions put to him, through the chair, by members of the Council. The letter from Mr. Peter Daniel, of the Metropolitan Hospital, which Mr. Spencer-Daniell had handed in, was read.

Mr. Smith put in testimonials which had been given to Mr. Rafter in 1906.

The Council deliberated on the case *in camerâ*.

Mr. Rafter, Mr. Spencer-Daniell, and strangers having been re-admitted, the President announced the judgment of the Council as follows:—

Mr. John Rafter, I have to announce to you that the Council have found the facts alleged against you in the notice of inquiry have been proved to their satisfaction, and that they have adjourned the further consideration of your case to the May Session of the Council, when you will be expected to be present and to produce evidence as to your conduct in the interval.

Mr. Spencer Daniell, the Council have deliberated on your case, and have passed the following resolution:—

"That the facts alleged against you in the notice of inquiry have not been proved to the satisfaction of the Council. The case against you is therefore at an end."

The Council considered the case of Joseph Fitzgerald, formerly registered as of 59, Red Rock Street, Liverpool, but now as of Beach Buildings, Queenstown, Co. Cork, Lic. R. Coll. Surg. Irel., 1871, Lic. R. Coll. Phys. Irel., 1873, who has been summoned to appear before the Council on the following charge:—

(1) "That you have acted as cover to an unqualified person, namely, Mr. Hamilton Williams Jolly, and knowingly enabled him to attend and treat patients and otherwise to engage in medical practice as if the said Hamilton Williams Jolly were a duly qualified and registered medical practitioner.

(2) "That you knowingly allowed the said Hamilton Williams Jolly to fill up and sign in your name certificates of death and vaccination in November or December, 1905, and in June, 1907, whereas in fact you had not attended or seen the patients in any of the cases, but the said Hamilton Williams Jolly had alone attended and seen them;

"And that in relation thereto you have been guilty of infamous conduct in a professional respect."

Mr. Fitzgerald was called, but did not answer to his notice.

The Solicitor having proved the sending of the notice, which he read, proceeded to lay the facts of the case before the Council.

The Solicitor read the evidence which had been given by Mr. Hamilton Williams Jolly and Mr. Fitzgerald at the inquest on Jessie Gogarty. He gave a history of the case, and also read letters written by Mr. Fitzgerald to the Registrar and to himself in answer to inquiries and to the notice.

The Council deliberated on the case *in camerâ*.

Strangers having been re-admitted, the President announced the judgment of the Council as follows:—

The Council have judged Joseph Fitzgerald to have been guilty of infamous conduct in a professional respect, and have directed the Registrar to erase from the *Medical Register* the name of Joseph Fitzgerald.

The Council then adjourned.

THIRD DAY.—THURSDAY, NOVEMBER 28TH, 1907.

The minutes of the last meeting were read, and, as amended, confirmed

The Council proceeded to the consideration of the case of John Papa Nicolas, registered as of 87, Dowanhill Road, Catford, S.E., M.R.C.S. Eng., L.R.C.P. Lond., 1904, who had been summoned to appear before the Council on the following charge:—

"That you have systematically canvassed in Catford for patients, by personal visits to patients of Mr. Thomas William Atkinson and to others, both while you were in the employment of the said Thomas William Atkinson and subsequently, and that in the course of such canvass you disparaged the qualifications and skill of the said Thomas William Atkinson and extolled your own, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainants in this case were the London and Counties Medical Protection Society.

Mr. Papa Nicolas attended in answer to his notice, with Mr. H. J. Randolph Hemming, his solicitor, and witnesses. The latter gentleman was accompanied by a lady, who acted as his adviser, and by a female shorthand writer.

Dr. Hugh Woods attended on behalf of the London and Counties Medical Protection Society, the complainants, also with witnesses.

On question from the chair, Dr. Hugh Woods stated that he had no objection to the presence of witnesses during the hearing; but on Mr. Hemming being asked the same question, he took exception to their presence. Witnesses, therefore, by direction from the chair, withdrew.

The Solicitor having read the notice, Dr. Hugh Woods proceeded to open the case for the complainants.

Dr. Woods called Mr. Thomas William Atkinson, M.B., B.S., R. Univ. Irel., of Berrymead, 78, Bromley Road, Catford, as a witness. He read Mr. Atkinson's statutory declaration, and questioned him as to its accuracy, which he confirmed.

Mr. Atkinson was then severely cross-examined by Mr. Hemming, who, however, was unable to materially shake the statement brought forward by Mr. Atkinson. In the course of the cross-examination, the Legal Assessor of the Council intervened, and on behalf of the President, requested Mr. Hemming to confine his questions to the occasions when Mr. Papa Nicolas had, as alleged, used his opportunities to disparage Mr. Atkinson.

The Legal Assessor at a later stage again objected to Mr. Hemming's cross-examination of Mr. Atkinson. in regard to a conversation which had not taken place in his presence.

Mr. Hemming cross-examined Mr. Atkinson in regard to the statutory declarations which had been prepared in support of the charge, and read statutory declarations made by several of the witnesses contradicting those previously made by them in support of the charge, and put in a declaration by Mrs. Lavallin.

Mr. Hemming asked to see the original letter of complaint. The Council's Solicitor explained that the documents to which parties were entitled were those which were sent to the Council in support of the charge or in answer thereto.

Mr. Hemming pressed his application for the production of the document, and asked for an adjournment to enable him to apply to the Court for a *mandamus*.

Dr. Woods having expressed his willingness that his letter of complaint should be produced, the Council allowed the letter to be read by their Solicitor, and Dr. Woods undertook to supply Mr. Hemming with a copy.

The Legal Assessor explained the procedure of the Council in regard to the matter.

Mr. Atkinson was then re-examined by Dr. Woods, with several interruptions by Mr. Hemming.

Mr. Atkinson answered a question put to him, through the chair, by a member of the Council.

The Council then adjourned.

FOURTH DAY.—FRIDAY, NOVEMBER 29TH.

The minutes of the previous meeting having been read and as amended confirmed, the Council proceeded to the consideration adjourned from Thursday, November 28th, of the case of John Papa Nicolas, registered as of 87, Dowanhill Road, Catford, S.E., M.R.C.S.Eng., L.R.C.P.Lond., 1904.

The complainants in this case were the London and Counties Medical Protection Society.

Mr. Hemming, defendant's solicitor, on the case being called, stated that he had applied for writs of prohibition and of *mandamus* against the General Medical Council and against John W. Atkinson.

The Council having deliberated *in camerâ*, it was announced, on strangers, etc., being re-admitted, that the case was adjourned until the next session of the Council.

The Council next considered the case of William Henry Roberts, registered as of 63, Lower Mount Street, Dublin, Lic. R. Coll. Phys. Edin., 1885, Lic. R. Coll. Surg. Edin., 1885, who had been summoned to appear before the Council at 4.30 p.m., on November 28th, on the following charge:—

"That you have knowingly assisted certain persons who are not registered as dentists, namely, Mr. Keogh, of No. 4, Lower Mount Street, Dublin, and Mr. John Blake Dillon, Messrs. William-Steyn and Mr. M. William-Steyn, all of 23, Rathmines Road, Dublin, in performing operations in dental surgery by administering and offering to administer anæsthetics, and have so enabled these persons to treat patients and to engage in dental practice as if they were duly qualified in dentistry and dental surgery, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainants were the Irish branch of the British Dental Association.

Evidence having been gone into, the President, after the Council had deliberated *in camerâ*, announced that it had been decided that the defendant was to come before the Council next May for judgment.

The Council then proceeded to the consideration of the case of John Bernard Gabe, registered as of Pentrepoth House, Morriston, Swansea, Lic. Soc. Apoth. Lond., 1881, Lic. Fac. Phys. Surg. Glasg., 1881, who had been summoned to appear before the Council on the following charge:—

"That you have employed as your assistant in connection with your professional practice a person not duly qualified or registered under the Medical Acts, namely, Mr. Frank Hannah, and have knowingly allowed him to attend and treat patients in respect of matters requiring professional discretion or skill, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainant was Mr. John Jenkins, of Temperance House, Tirdeunaw, near Swansea.

And of the case of Morgan Watkin Williams, registered as of Trewernen, Llantwitfardre, Pontypridd, South Wales, M.B., Bac. Surg., 1900, Univ. Glasg., who had been summoned to appear before the Council on the following charge:—

(1) "That you, being a duly qualified and registered medical practitioner, while acting as assistant to Mr. John Bernard Gabe, also a duly qualified and registered medical practitioner, by your countenance, assistance, and co-operation knowingly enabled an unqualified and unregistered person, namely, Mr. Frank Hannah, who was also acting as assistant to the said J. B. Gabe, to attend and treat patients and engage in medical practice as if the said F. Hannah were duly qualified and registered;

(2) "That you signed a certificate of death, namely, of Alice Mary Jenkins, which stated that you had attended the said Alice Mary Jenkins in her last illness, and that you last saw her alive on May 4th, 1907, whereas in fact you had not so attended her or seen her, but the said Frank Hannah had alone attended and seen her;

"And that in relation thereto you have been guilty of infamous conduct in a professional respect."

Mr. G. F. Evans, K.C., M.P., appeared for both the defendants.

Evidence on both sides having been heard, the President, after the Council had deliberated *in camerâ*, announced (1) that the facts against Mr. J. B. Gabe had not been proved to the satisfaction of the Council, and (2) that the facts alleged against Mr. M. W. Williams had been proved to the satisfaction of the Council, but that he was called upon to come before the Council next May for judgment.

The Council then considered the cases of Arthur James Arch, of Leicester House, Coventry, registered as Mem. R. Coll. Surg. Eng., 1904, Lic. R. Coll. Phys. Lond., 1904; William Walter Fenton, of Avonmore, Warwick Road, Coventry, registered as M.B., Bac. Surg., 1893, M.D., 1894, Univ. Dubl., Lic. Midwif. K.Q. Coll. Phys. Irel., 1884; Thomas Alfred Hird, Norton House, Coventry, registered as M.B. Mast. Surg., 1882, M.D., 1900, Univ. Edin.; and William James Pickup, Swanswell, Coventry, registered as Mem. R. Coll. Surg. Eng., 1876, Lic. Soc. Apoth. Lond., 1877, M.B., 1880, M.D., 1893, Univ. Lond., who had been summoned to appear before the Council on the following charge:—

"That you have joined with other registered medical practitioners in forming and are one of the medical staff of a dispensary, namely, the Coventry New Dispensary Service, which systematically canvasses for patients, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainants are Andrew St. Lawrance Burke, Gosford House, Coventry, registered as Lic., Lic.

Midwif., 1895; R. Coll. Phys. Irel.; Lic., Lic. Midwif., 1895; R. Coll. Surg. Irel.; Alfred Pytches Blanchard Ellis, of Earlesdon House, Earlesdon, Coventry, registered as Lic. Soc. Apoth. Lond., 1896; and John Inman Langley, formerly registered as of Parkside Arcadian Gardens, Bowes Park, N., but now of 14, Warwick Road, Coventry; Mem. R. Coll. Surg. Eng., 1898, Lic. R. Coll. Phys. Lond., 1898, who were represented by Mr. McCardie, barrister.

Mr. J. A. Hird unfortunately died on November 28th.

Evidence having been heard, the Council, after deliberating *in camerâ*, found that the case had not been proved.

The motion by the President, as Chairman of the Companies Bills Committee, "That the following be appointed additional members of the Companies Bills Committee, Sir Charles Ball, Dr. Langley Browne, Mr. Morris, and Dr. Kidd," was carried.

The report from the Education Committee, proposed by Dr. Mackay, seconded by Sir John Moore, was agreed to, adopted, and to be entered on the minutes.

The report from the Pharmacopœia Committee, proposed by Dr. Norman Moore, seconded by Dr. Lindsay Steven, was agreed to, adopted, and entered on the minutes.

The following reports from the Examination Committee, proposed by Dr. McVail, seconded by Mr. Young:—

(*a*) On the returns as to examinations for entrance to the Navy, Army, and Indian Medical Services since the last Session of the Council.

(*b*) On the final examinations (July, 1907) of the Apothecaries' Hall, Dublin.

After some remarks from Dr. Adye Curran with reference to inspectors, were received, adopted, and entered on the minutes.

A report from the Students' Registration Committee, proposed by Sir Hugh Beevor, seconded by Dr. Norman Moore, was received, adopted, and entered on the minutes.

Mr. Henry Morris was unanimously appointed Treasurer to the Council, owing to the resignation of Dr. Pye-Smith.

A vote of thanks to the President was proposed by Dr. Norman Moore, seconded by Sir J. Moore, and carried by acclamation.

The Council then rose.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Dec. 1st, 1907.

Artificial Abscess.

A few additional remarks are necessary to complete what we have already written on artificial abscess.

Prompt reaction to the chemical agent injected, constitutes one of the most favourable signs and the rapid and abundant formation of pus should excite no anxiety, as it is a proof of the resisting power of the organism.

Towards the third day the pus begins to form and the abscess opens spontaneously between the sixth and fifteenth day. According to Fochier, the abscess should never be opened, but generally, as soon as fluctuation is well evident and above all if the patient has entered on convalescence, the collection is incised and dressed antiseptically. The wound cicatrizes slowly, a month or more being sometimes neccessary.

The effects of the abscess are as follows:—Immediately after the injection the temperature may rise a little, but as soon as reaction sets in it falls, the pulse becomes less frequent, and the quantity of urine increases, and if albumin exists it is reduced in quantity. This improvement may take place within twelve hours after the injection, but the temperature becomes normal only when suppuration is formed.

The therapeutic method of this artificial pyogenesis may be resumed as follows:—(a) Artificial abscess seems to possess indisputable therapeutic effects in a patient suffering from infection of no matter what source; (b) artificial abscess is indicated in all cases of ordinary septicœmia, after other methods of treatment have failed; (c) an injection of 20 drops of sterilized turpentine into the cellular tissue is sufficient to produce it. The intensity of the local reaction that the injection provokes is in direct ratio with the degree of resistance of the patient; (d) the incision of the abscess must coincide with local abundant suppuration and improvement in the alarming general symptoms; (e) from the moment of the injection to complete cicatrization, the artificial abscess must be treated antiseptically.

Artificial abscess, it must be confessed, is at most an empiric treatment, as its mechanism has never been established, either clinically nor by experiment.

Fochier considers it to be an organ of attraction for the microbes and the toxines.

Dieulafoy is a partisan of the hippocratic ideas of metastasis. For Trifon, the abscess neutralizes the toxines, while Pinna and Mercaudino consider it to be a laboratory for the formation of bactericide, antitoxic substances which penetrate by absorption into the lymphatic circulation.

Thiosinamin in Heart Disease.

For the last few years Prof. Rénon has been utilizing the curious properties of thiosinamin to soften cicatricial tissue, for the treatment of certain valvular diseases of the heart, cardiac symphysis and arterio-sclerosis.

For mitral affection no improvement was observed, but he had considerable success in aortic disease. Patients who could not mount stairs nor carry heavy loads were able to make those exercises without any or but very slight oppression. The arterial tension was lowered, and albumin diminished or disappeared. However, the stethoscopic signs were in no way modified, no difference in the intensity of the souffle was ever remarked. Its effects were limited to reducing the dyspnœa and lowering the arterial tension, advantages that can be appreciated. The solution he uses is:—

Thiosinamin, 15 gr.
Distilled water, 7 dr.

Each subcutaneous syringe contains four-fifths of a grain. Five syringes are injected at the one time, beneath the skin of the abdomen, and repeated every day for a month. The injections are not painful, nor do they produce indurations.

GERMANY.

Berlin, Dec. 1st, 1907.

At the Medical Society, Hr. L. Michaelis reported that he had been successful in producing a direct reaction in a case of hereditary syphilis by making use of a serum of very high power. The reaction of 0.01 corresponded to 0.2 of the other that had been discovered; it was therefore 20 times stronger. For proving the reaction syphilitic liver extract was employed. The reaction was checked by excess of liver extract. From this it followed that this contained the antigen, the material within the patient on the other hand, the "antistoff."

Hr. Falkenstein gave a retrospect of

The Treatment of Gout by Hydrochloric Acid,

after observations extending over five years He reminded his hearers of an address on the same subject delivered before the Society four years ago. He then discussed the nature of gout and its treatment by hydrochloric acid. Since that time he had daily given 50 to 60 drops of hydrochloric acid, and had also carried out the same course of treatment in a large number of other cases. The large doses of hydrochloric acid were perfectly harmless, so long as they were sufficiently diluted and taken along with a sufficient quantity of food. The alkalescence of the blood was not diminished by the acid, nor were the teeth or organs in any way injured.

The speaker proceeded on the assumption that uric acid was harmful only when it was associated with alkalies whereby its tendency to deposit became heightened. In gouty patients the primary fault lay in a deficiency of hydrochloric acid in the stomach. It was only then that imperfect digestion of nuclein-albumen arose, with excessive alkalescence. Where, however, there was disease of the mucous membranes of the stomach, the hydrochloric acid was otherwise abnormal and the deficiency of it was of subordinate importance. During the attack of gout itself hydrochloric acid had no effect; it should rather be used permanently during the intervals.

The objection that not infrequently there were cases of deficiency of hydrochloric acid without gout he rejected; there must be a primary antacidity; imperfect digestion of nuclein-albumen could only originate then, along with excessive alkalescence.

He had treated 390 cases by this method, and divided them into three groups according to their severity and the age of the patient, on which the results of treatment depended. It was only in the most severe and most chronic cases that the progress of the gouty changes could not be influenced.

Hr. Kraus considered the most important thing in the treatment of gout to be the food—the long-continued giving of foods containing no uric acid. Along with this, the long-continued use of mild alkalies appeared to have an effect on the frequency and severity of the attacks.

Hr. Brugsch, in opposition to the reader of the paper, considered gout to be not a hereditary disease of the stomach, but a diseased nuclein tissue change. If the hydrochloric acid constituent of the stomach was greater then the quantity of pancreatic secretion increased and the balance remained always the same. Hydrochloric acid did not cure gout; the chief thing was the diet.

Hr. Falkenstein meant to say that vegetarians even did not get free of their gout, whilst under the use of hydrochloric acid, patients improved, notwithstanding they were taking fresh meat in large quantities.

At the meeting of the 13th ult., Hr. Albu showed a female patient, æt. 72, who for seven years had suffered from a copious fluid discharge from the rectum, which had been collected and examined. It was found to consist of watery thin mucous. Just above the anus a rather large warty growth was felt, which the patient could easily force down by straining. The tumour was certainly not malignant, as a portion examined under the microscope showed. Considering the age of the patient, it was deemed advisable not to operate.

He then showed a tumour taken from a woman, æt. 62, that had been removed two years previously. Here also the growth could be made to protrude from the anus. It was clearly malignant. The removal was carried out by the late Prof. v. Bergmann. Recovery was normal, and the patient had had two years' good health.

Prof. Ewald is about to retire from the editorship of the *Berliner Klinischen Wochenschrift*, and will be succeeded by Dr. Hans Kohn, of that city.

AUSTRIA.

Vienna, Dec. 1st, 1907.

Fistula Gastrocolica.

Falta presented a case of gastrocolica to the Gesellshaft which he operated on in 1902, who came to him then with typical stenosis from ulceration of the stomach, which demanded gastro-entero-anastomosis. In spite of this operation, the ulceration of the stomach still persisted, 1904-5 and 1907. A tube was passed into the stomach, and fæces extracted or vomited. Air was next blown into the rectum, passing up the descending colon with a metallic noise and rush into the stomach, whence it was ejected by the mouth. Water coloured with methylene blue was injected through the rectum, which took the same course as the air, and was thrown out by the mouth. The Röntgen rays confirmed the passage of the air out of the colon into the stomach by a direct communication through which the contents of the colon passed readily into the stomach. Before this time no symptom indicated that a direct communication existed between the stomach and colon. He thought there was nothing left but to perform another operation to correct the morbid change.

Holznecht said he had one of these rare cases where the history of anastomosis appeared to be established, but it was found later that the pylorus was perfectly patent, and no other communication existed.

Eiselberg thought that gastro-enterostomy should only be performed on careful deliberation after opening the parts, and before severing any of the internal organs. There are many of the pyloruses that are unsuitable for removal at one time, but after the ulcers have healed can be removed with advantage.

Traumatic Hæmatoma.

Eiselberg exhibited a boy, æt. 16, with a large soft fluctuating swelling on the left side of the head. Around the base of the tumour it was as hard as bone and painless on pressure, the latter being true of the whole swelling.

The history of the case was that twelve days before this exhibition he had been playing with other boys, and was caught up by the hair of the head on the left side in their fun. On the following day he found it swollen a little, but gave it no further heed; on the second day it was larger, and has gradually increased every day till it has reached the present dimensions.

Syphilis and Valvular Disease.

Fein presented a young soldier, æt. 20, with insufficiency of the mitral valve and complete paralysis of the left vocal cord. The Röntgen rays showed an increase of the heart in all directions, as seen from the pulsating shadow, but no aneurysm could be detected. From the history the young man had syphilis six months previously. Energetic anti-syphilitic treatment was immediately commenced, and the patient improved in voice and general health within three weeks, although the vocal cord had been greatly atrophied The great difficulty in breathing had quite disappeared, and the cardiac sensation had returned to its normal condition. After commencing the inunctions, the vascular walls began to repair rapidly, which is unusual in fresh cases. The widening of the aorta soon began to contract, and thus relieve the vocal nerve.

Perl-Cyst.

Tertsch presented a young female, æt. 20, with a cyst in the anterior chamber of the right eye, the result of a stab. It appears that some of the epithelial cells were carried through the cornea into the anterior chamber, where they commenced to proliferate and form a sac like a hair bulb or gland, and finally attach itself to the iris. Having once got a root, a cyst was formed, till a good-sized tumour was formed, but happily began to break down in the centre. These neoplasms resemble the atheroma or cholesteatoma in the destruction of the eye, and should be removed at the earliest opportunity, as the prognosis is always favourable.

Foreign Body in Trachea.

Marschitz showed a boy, æt. 5, who had allowed a fish-bone to get down the trachea and it was caught at the bifurcation of the bronchi. There was no choking, but sudden aphonia appeared, with difficulty in swallowing. With the laryngoscope the bone could be seen lying in the sub-glottic space directly in the median line. The boy was narcotised, and the body caught with Schrotter's forceps and brought up to the glottis, where difficulty arose to get it through. The child, feeling the pain, made a sudden move, causing the operator to press the body tighter, which broke, allowing part of it to fall back into the bronchi, where it could afterwards be seen with the bronchoscope; it was removed with another pair of long forceps. In spite of this successful removal with the bronchoscope, he thinks tracheotomy the safer operation, as there is not such fear of œdema of the glottis.

CONTINENTAL HEALTH RESORTS

1.—A SUDDEN FLIGHT TO THE SUNNY SOUTH.

[From Our Continental Correspondent.]

Nice is undoubtedly the most important town on the French Riviera. It has become a general favourite with all nations, and with the advent and persistency of the November fogs, the annual migration to the sunny south has been hastened. Thanks to the excellent service of the South-Eastern and Chatham Railway, with their new and fast boats viâ Dover and Calais, Folkestone and Boulogne, and special train service of the popular P.L.M., the Riviera can be reached in comparatively few hours under exceptional circumstances of enjoyable comfort.

The climate of Nice and of Cimiez is dry and bracing, such as to strongly stimulate metabolism. Glorious excursions far and near, and delightful walks in the immediate environs, afford the necessary attractions to those in search of health; and for those who are suffering from nerves, throat troubles, or rheumatic tendencies, Nature and Art appear to have joined hands to render the beautiful region of Cimiez (the favourite resort of her Majesty the late Queen Victoria) one of the most desirable places for winter residence along the Riviera. Excellent hotels also abound, each endeavouring to excel the other in all matters of hygiene, cuisine and comfort, thus leaving power to the visitor to decide according to his tastes or his purse. I would specially draw attention to the recently constructed "Winter Palace" and Hermitage, luxuriously furnished with all home-like comforts, and commanding, as they do, a magnificent panorama, surrounded on all sides by well-kept and picturesque gardens, rejoicing in an atmosphere free from dust and noise. Both ends of this charming resort are to be strongly commended, so that it is purely a matter of personal choice where hotels are all good and do their utmost to satisfy the tastes and meet the wishes of their guests. Excellent concerts twice daily delight the musical ears of those who spend the mornings and afternoons inhaling the ozone-laden atmosphere, together with the tonic woodland and perfume of flowers. Cimiez is not a place for chronic invalids, and it is well that physicians should bear this fact in mind when deciding on a winter health resort for patients; but for people who are convalescent and require bracing up it stands unique. Well-known physicians, English and foreign, are to be found in this ideal spot.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

TREATMENT OF INCIPIENT MENTAL DISEASE.—The question of the treatment of early and "border-line" cases of mental disorder in the Edinburgh Infirmary, which caused a good deal of discussion some years ago, and was then dropped for the time being, has again been brought before the public by a letter from Dr. Clouston, and an editorial which appeared in the *Scotsman* of November 29th. Dr. Clouston recapitulates the facts which were brought out three years ago —the general favour with which the proposal to treat such cases in the infirmary was received by the medical profession; the approbation of the Commissioners in Lunacy; and the welcome of the philanthropic public. The managers of the infirmary, impelled largely by financial considerations, however, decided that the time had not yet come to institute such wards. Since that time, says Dr. Clouston, wards for suitable mental cases have been successfully established in America, Canada, and Australia. "To have a patient suffering from a short attack of child-bed delirium formally committed to a mental hospital on two doctors' certificates and a sheriff's order, when a few weeks' treatment in suitable wards in the Royal Infirmary would cure her disease and restore her again to her family, is almost a scandal." While arguing that this is a question for the public, and not merely doctors to settle, Dr. Clouston goes on to say that the overwhelming opinion of medical men who are specially interested in mental diseases was in favour of the scheme four years ago. Sir Arthur Mitchell, Sir John Tuke, Sir John Sibbald, Dr. Fraser, Dr. Macpherson, Dr. Urquhart, Dr. Robertson, Dr. Bruce, and Dr. Easterbrook are quoted as having supported it. Every general practitioner he has spoken to has backed up his opinion that such wards would be of enormous use, and are urgently needed. Glasgow is ahead of us in this respect, having provided for the treatment of incipient and uncertified mental disease in a way that is doing a great service to the most helpless class of mankind. It appears to Dr. Clouston that the time has now come for the managers of the infirmary to take the matter up. In addition to providing early treatment for cases which are now allowed to drift into incurable mental conditions, such wards would have the great advantage of helping to strengthen in the public mind a realisation of the fact that insanity is a bodily disease, and so remove the reproach or stigma which ignorance or prejudice attach to it. It will be a great gain to Dr. Clouston that he has secured the aid of the *Scotsman* in his crusade, and the strongly-written editorial in which reference is made to his letter will strengthen the hands of those who urge that mental wards are required. The editorial speaks of it as "a highly deserving cause," and emphasises "how seriously defective is our equipment for treating insanity in its curable stages" compared with the provisions made on the Continent. The ground taken is that the infirmary was compelled to defer the scheme because it had other work on hand; now the contributors should recognise that they have an enlarged responsibility, and provide funds for Dr. Clouston's ideal. "It would complete on a side hitherto neglected a great charitable institution for the help of suffering. It would extend the sphere of experience and instruction available for a great medical school. It might even effect some saving in the public cost of maintenance of pauper lunatics in the asylums."

TRINITY HOSPITAL FUND APPOINTMENTS.—The Town Council have appointed the following gentlemen Medical Officers to the Trinity Hospital Fund:—Dr. James Murray, Dr. John McLaren, Dr. J. A. H. Duncan, and Dr. Balfour. The Medical Officership was formerly held by the late Dr. Dunsmure, but when it became necessary to elect a successor, the Council resolved to divide the appointment and elect four medical officers resident in different parts of the city.

SCOTTISH ORPHAN HOMES.—The thirty-sixth annual meeting of these homes, founded by the late Mr Quarrier, was held in Glasgow on November 27th. In the homes on October 31st, 1907, there were 1,268 children—687 boys and 599 girls. In the consumption sanatoria were treated 336 patients during the year. and there were 2,030 attendances at the dispensary. The first home for epileptics has been in operation for 15 months, and is now filled with 30 young men Among those who spoke at the meeting were Dr. W. L. Reed and Professor Stockman. "Quarrier's Homes," as they were formerly called, arose through the labours of one man, and are among the best known charities in Scotland. Everyone has always recognised the admirable way in which they were conducted, and as the Scottish Orphan Homes they will remain as an enduring monument to the memory of their founder, Mr. James Quarrier.

BELFAST.

ULSTER MEDICAL SOCIETY.—ANNUAL DINNER.—The annual dinner of this society was held in the Medical Institute, Belfast, on Thursday, 28th ult., and was a most successful function. The chair was occupied by Dr. John McCaw, the President of the Society. The toast list was brief, and the intervals were filled by songs and recitations by members. After the toast of "The King," proposed by the President, had been drunk, Mr. A. B. Mitchell proposed "The Lord Lieutenant and Prosperity to Ireland," and in doing so appealed to those present to help in promoting this prosperity by spending their holidays in their own country, of the remoter parts of which most know so little. The High Sheriff of Belfast, Dr. Peter O'Connell, J.P., replied, and in an eloquent speech prophesied brighter days for Ireland, in which the members of our profession would occupy important places as the apostles of preventive medicine. "Our Guests" was proposed by Dr. Walton Browne, and responded to by President Hamilton, of Queen's College, and Dr. Warnock, of Donegal, President of the Ulster Branch of the British Medical Association The health of the President of the Society was proposed by Dr. J. B. Moore, and, in replying, Dr McCaw gave some particulars of a golf prize which he is offering for competition among the members this winter. Decidedly the most entertaining item of the evening's programme was the reading by Dr. R. J. Johnstone of a poem, which he said he had been privileged to take down in shorthand on the opening of the Tuberculosis Exhibition in Belfast last week, "The Last Dying Speech and Confession of Bacillus Tuberculosis, Esq., late of Belfast, with a Full History of his many Crimes and Murders, and his most Edifying End." The allusions to the work of Sir John Byers, Dr. Thomas Houston, and others named in the poem were received with great applause, and after the reading Dr. Johnstone quickly disposed of many copies at sixpence each for the benefit of the Royal Medical Benevolent Fund of Ireland.

LAST DYING SPEECH AND CONFESSION OF BACILLUS TUBERCULOSIS, ESQ.

'Twas a weariful bacillus, old and faded, worn and gray,
Who, drying on the coverslip spake thin and far away:
"Proud mortal, ere my form you steep in carbol fuchsin stain,
Ere I bathe in acid alcohol again and yet again,
I would fain recount my story to your sympathetic ear;
But wet my lips with saline, for the Bunsen flame's too near.
I was once a gay young microbe, and I floated round the town,
Wrapped up in well-dried mucus, light as the thistle down.
My race was old and mighty; Koch made us known to fame,
For the Tubercle Bacillus is my far-renowned name.
In the heyday of my vigour, when the world and I were young.
My aims were high—I sought and found the apex of the lung.
With a chemotactic longing leucocytes came flocking round,
We dallied fondly till we changed th' expiratory sound,
So Professor Lindsay spotted me, and ordered me to quit—
I find fresh air unhealthy, I thought it best to flit.
More cautious now, I sought to rest embraced by giant cells,
Within a deep cervical gland that near the phrenic dwells.
Unhappy choice! for Surgeon Kirk removed me all complete,
With half a foot of jugular and half a pound of meat.
My bonds with man, so rudely torn, gave all my faiths a shock,
I doubted—'Am I human? p'raps I ought to try the flock;
I may be bovine after all; since man evicts me still
I'll look for compensation under Mr. Birrell's Bill.
So I found a country dairy, just back of Grosvenor Street;
A friendly stripper took me in and lodged me in her teat
Here, amid rustic sights and smells, I ruralised a space,
Then borne upon a stream of milk rejoined the human race.
Snug in mesenteric nook I soon addressed my mind,
By fission's simple easy arts, to propagate my kind.
Over the serous surface quick spread my hardy brood;
Ascitic fluid came in floods—we found it very good.
But Thomas, prince of opsonists, by fell mischance came nigh:
He took the index of our host, and found it very high.
Treatment on scientific lines we heard him then discuss—
Tuberculin, one milligramme, soon decimated us!
Fleeing the slaughter of my tribe, my powers now rather weak,
With hearty zest I made a nest upon a damask cheek.
There, in an apple-jelly speck, I'd hoped to end my life,
But X-Rays pierced me to the quick—I left th' unequal strife.
Since then I've wandered round Belfast, but find the world grown hard,
Man's bowels yearn no more for me, and bovine beasts are barred.
A band, with demonstrating ways and eloquence profound,
'Gainst me the people's passions raise, and loud the tocsin sound.
Chief instigator of the fray, Sir John—'No quarter'—cries,
When knights were bold they fought with things—well, nearer their own size!
A surgeon, too, a vet. as well, physicians add their breath,
And gents from sanatoria, where we are fed to death,
And several more who show my crimes, while all the people stare;
Though many a fee they've got for me—they'll get no more, I swear!
For now those oft-respired airs, in which a microbe blooms,
Are blown to Hades by the breeze denouncing 'Stuffy Rooms.'
They've cleared away the dust, in which I used to lurk and hope;
They hear 'What other nations do'—the Dutch are fond of soap.
I lived with darling children once, in tissues soft as silk;
I simply can't get near them now—they sterilise the milk!
Aye, worse than that—excuse the tear of pity in my eye—
The poor milch cows that harbour us, for that offence must die.
The very things I most detest I strive in vain to flee,
All round it's sunlight, food, fresh air, to kill 'the Scourge'—that's me.
Why, many good, hard-drinking souls are sorely put about—
They're going to dock the beer, because I like men fond of stout.
At peril oft before I scoffed, I've managed to outpace
The dreaded phagocyte's pursuit, his fatal slow embrace;
I've laughed to scorn iodoform, and once—'twas rather warm—
Passed through a disinfector, hid in blankets, without harm!
But at the fate we've met of late imagination swoons—
Frizzling to death by millions in combustible spittoons!
Well, when assailed by these alarms I had begum to quake,
Professor Symmers welcomed me for old acquaintance sake.
Said he—'Can I believe my eyes, and have we met at last,
Sole Tubercle Bacillus left alive in all Belfast?
Nay, come; I'll gladly take thee in, and gladly give thee place
Upon this spacious agar slope, last scion of thy race.
With glucose will I nourish thee, and human serum, too,
And thou shalt grow apace, and I will put thee oft on view—
The parasite that lived and throve—believe it now who can—
In pre-Exhibition ages on pre-Exhibition man.'"
The murmur ceased, the microbe passed; the relics are on view—
A crimson speck, in balsam, on a ground of methyl blue.

CEREBRO-SPINAL FEVER.—At the last meeting of the Public Health Committee, Dr. Gardner Robb reported that for some time past he has been using a new serum, not yet upon the market, for the treatment of cerebro-spinal meningitis cases, and that the results have been very much better than those obtained from any of the other serums he has tried. Details of this serum will be awaited with interest, as Dr. Robb's very extensive experience gives great weight to his words, and those who know his caution will be the first to expect a good deal of a remedy of which he speaks as he does of this.

LETTERS TO THE EDITOR.

SANDOW AS PHYSICIAN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Ours is a great and noble profession. It involves complete self-sacrifice. Our mission is to succour suffering humanity without any kind of sordid consideration. How much we get paid for arduous services calling for expenditure of our best vital forces, or whether we get paid at all, matters not one jot; we must give ourselves up body and estate to our altruistic mission. With feelings like these which inspire all of us, I am certain every one of your readers has, with me, welcomed the establishment in London within the past few weeks of two noble institutions which promise to bring speedy relief to crowds of sufferers to whom the slow, uncertain methods of scientific medicine are of no use. These two great institutions, "The Nauheim," in George Street, and "The Sandow," in St. James's Street, have been sufficiently referred to in your columns, and have been fully described in articles in the *Times* and all the lay Press. "The Nauheim" establishment cures all the maladies which are uncertainly dealt with at Nauheim itself, besides a good string of diseases not dealt with at Nauheim. It does this by the Nauheim bath treatment and other wonderful methods which a purblind medical profession is not cognisant of. "The Sandow" institution cures the same string of maladies—a few more or a few less—by marvellous muscular exercises of which a quite blind medical profession has never perceived the value. "The Nauheim" institution assures us—although no reasonable man can need such assurance—that the profession was represented by eminent doctors at its opening, and that they are flocking with their patients to enter upon a "new era in medicine." It modestly refrains from giving the name of a single doctor—modesty which every member of the profession, although sympathisingly, must regret. "The Sandow" institution claims, no doubt with equal right, the support of leading doctors, and quite properly puts the name of a distinguished supporter in its advertisements. This gentleman, it seems, is Sir Conan Doyle, who, we are told, has given his imprimatur to the work of Mr. Sandow. I am sure we would all like to back up Sir Conan in his philanthropic endeavours in this connection, and we should all be glad to know from him how best to set about it. Can you, Sir, ask Sir Conan Doyle for an explanation through your widely-read pages?

I am, Sir, yours truly,
AN OBSCURE PRACTITIONER.

November 29th, 1907.

[We regret our correspondent, a well-known member of the profession, prefers to withhold his name, and we trust that this fact may not prevent Sir Conan Doyle from acceding to his request. Sir Conan Doyle now holds a position of complete detachment from professional life, and it would be most interesting to learn his views with regard to Mr. Sandow's new pathological ideas and therapeutical practices.—ED. M. P. AND C.]

DO MEDICAL MEN ASSIST IN THE SALE OF PROPRIETARY MEDICINES?

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—The workers of the medical profession, *i.e.*, those who have to gain their living solely from what the practice of their profession produces, will be grateful for your leading article on, "Do Medical Men Assist in the Sale of Proprietary Medicines?" Every sensible man of business knows that they do assist, and that for many practitioners the Pharmacopœia might almost as well be non-existent, as So-and-so's special preparation is almost invariably ordered. I grant that the manufacturing chemist puts up many of the usual preparations in a pleasant and agreeable form—more pleasant that an ordinary prescription following the lines of the Pharmacopœia would probably be—but does that make it right that leaders of the profession should advise these proprietary or registered formulæ, which are frequently ordered to be dispensed in the original packages? If the Pharmacopœia is defective, it ought to be improved. If special tablets or mixtures are required, it ought surely to be possible to write a prescription for them. Why should medical men recommend some special firm's cod-liver oil, or emulsion, or other such preparation except through laziness; or why should they advise some tablet or varalette which is advertised in all the lay papers as obviating the necessity of incurring a medical bill? Recently I (and I presume most other medical men) have received a reprint of a paper by one of the leaders of the profession advocating the use of a proprietary article in septic throat cases. Need I point the moral that the intelligent but parsimonious public will, at any rate in the first instance, go to their chemist and get a bottle of these tablets, and thus in some cases avoid calling in a medical man, but in other cases the doctor, when called in, will find that a diphtheria has been too long neglected for serum treatment to be of avail.

Yours etc.,

James Hamilton, M.D., Q.U.I.

60, Sydney Street, Chelsea, Nov. 30th, 1907.

CLOSE OF THE MAGUIRE FUND.

To the Editor of The Medical Press and Circular.

Sir,—In sending you the final list of subscribers to the Maguire Fund, which is now closed, I wish to repeat my expressions of thanks to you and to the generous subscribers.

The fund realised in all £63 12s. 6d., a sum sufficient for all present requirements.

	£	s.	d.
Amount already acknowledged	£57	15	0
Miss Knox, Cranmore, Ballinrobe	1	0	0
T. Houghton Mitchell, M.D., Ambleside ...	1	1	0
Major G. H. Frost, I.M.S., Bakloh, Punjab	1	0	0
Dr. Humble, Corfe Castle, Dorset	0	5	0
Dr. J. Mills, County Lunatic Asylum, Ballinasloe	1	0	0
Dr. Elliott, Verulam, Natal*	1	11	6
	£63	12	6
Disbursed	13	3	6
Balance unexpended to date	£50	9	6

* Dr. Elliott, with kind forethought, wishes 10s. 6d. to go to the little boy as a Christmas present.

I am, Sir, yours truly,

R. B. Mahon.

Ballinrobe, November 25th, 1907.

MEDICAL NEWS IN BRIEF

Irish Medical Schools Graduates' Association.

A most successful evening was the result of the autumn dinner of the Association, held on Wednesday, November 27th, at the Hotel Cecil, the President, Sir John William Moore, in the chair. The autumn general meeting of this Association was held before the dinner, Sir J. W. Moore in the chair, when, after the ordinary business, a proposal concerning the formation of a northern branch, to include Manchester, Liverpool, Leeds, Sheffield, and other places near to them, was considered, which was approved by the meeting, the details being left to be worked out by the Council.

About 200 members and guests, including ladies, sat down to the dinner. Amongst those present were Sir John and Lady Moore, Sir James and Lady Digges la Touche, Sir Shirley Forster and Lady Murphy, Sir Dyce and Lady Duckworth, Colonel Sir R. Havelock Charles, General W. Carnell, Surgeon-General Sir Thomas Gallwey, Sir Charles Cameron Lamb, Dr. Macnaughton Jones, Dr. Fegan, Dr. James Little, Dr. F. J. and Mrs. Roberts, Dr. McVail, Dr. James Macan, Dr. and Mrs. Giles, Mr. and Mrs. Chas. Ryall, etc. After the usual loyal toasts, Dr. J. Macan presented the Arnott Medal to Sir R. Havelock Charles. This medal was founded in 1900 by Mr. Arnott in memory of J. Arnott for heroism or distinguished service on duty in civil life or in the naval or military services. It was awarded to Sir R. H. Charles for his very important services in epidemic diseases in India. Sir R. H. Charles said a few graceful words in acknowledgment. The toast of "Our Defenders" was proposed in a very humorous speech by Dr. J. Little, and responded to by Dr. Samuel Browne, R.N., and General William Carnell, the latter making a few terse and soldier-like remarks anent the service he represented. After "Our Guests" had been proposed by Dr. Fegan, and responded to by Sir J. Digges La Touche and Sir Shirley Murphy, Dr. Fred. Roberts gave the toast of "Our Guests" in a few quaint and amusing words, prefacing his remarks by expressing his surprise at having to propose this toast, as he himself was a Welshman. The President, in responding, after a few words about the propinquity of Ireland and Wales, called on Dr. Roberts for a song. Dr. Roberts sang "Tom Bowling," and, as an encore, "My Pretty Jane," in his well-known admirable style. The musical arrangements were in the capable hands (in Irish it would be mouths) of Miss Gertrude Woodall and Mr. Anderson Nicol, Miss Edith Pratt presiding at the piano.

Statute of Limitation.

At Runcorn County Court, on the 14th inst., before Judge Shiress Will, Dr. Carruthers, of Halton, sued George Knight, of 58, Park Road, Southport, "gentleman," for £53 11s. 6d., balance of an account for professional services.

Mr. A. Browne said Mr. Knight was formerly a well-known accountant in Runcorn, but retired some years ago. In 1890 Mr. Knight had a serious illness, and Dr. Carruthers attended him night and day, and had to call in a specialist. Mr. Knight had made two payments of £10, the last in 1897.

Mr. Knight now pleaded the Statute of Limitations, and his Honour said he had no alternative but to give judgment for the defendant. Mr. Browne asked that defendant should not receive costs, but his Honour said the plaintiff could have withdrawn the case when the Statute was pleaded, and he granted defendant costs.

Death under Chloroform.

Mr. Brighouse held an inquiry at St. Helens, on November 23rd, into the death of Richard Mayor, 52, a collier. Mayor died at the St. Helens Hospital on the previous Thursday, while being operated on by Drs. Cotton and Latham. Deceased had been treated for several years, off and on, by Dr. Valentine, of Earlestown, for hernia, and he on Thursday last decided that an operation was immediately necessary. Dr. Cotton said that the operation was started in the usual way, after the condition of the man's heart, etc., had been considered, but very soon after chloroform was administered Mayor collapsed. The operation had not actually been entered upon, and the man died. The Coroner said the percentage of deaths of people under chloroform was very small. Dr. Cotton said that was so. A verdict of "Death from Misadventure" was returned.

The Women's National Health Association.

A meeting was held during the past week at the Royal College of Physicians of Ireland, under the Presidency of the Countess of Aberdeen, for the purpose of inaugurating a Dublin branch of this Association. The meeting was very largely attended, and amongst the audience were a number of prominent members of the medical profession. Her Excellency, in an opening speech, said that the objects of the

Association were threefold. The first was a crusade against tuberculosis. The second the lowering of infant mortality, which was very high in Dublin and Belfast. The third was the improvement of school hygiene. Resolutions were passed inaugurating the branch, and appointing an Executive Committee.

In connection with this meeting it is interesting to note that at a conference of representatives of the Clinical Hospitals of Dublin, held last week, under the presidency of her Excellency the Countess of Aberdeen, it was unanimously agreed to recommend the various Hospital Boards to co-operate with the Women's National Health Association of Ireland in their efforts to provide adequate home treatment for tuberculosis patients.

Royal Medical Benevolent Fund Society of Ireland.

A QUARTERLY meeting of the Central Committee was held at the Royal College of Surgeons on Wednesday, November 27th. Present, Sir Francis Cruise (in the chair). A letter was read from Dr. Minchin, tendering his resignation of the post of hon. secretary and treasurer of the Co. Meath branch. His resignation was accepted, and the secretary was instructed to give the thanks of the Central Committee to Dr. Minchin for his services on behalf of the Society. Urgent applications for grants were then considred, and awards amounting to £54 10s. were made. The meeting then adjourned.

The Normyl Treamtent of Inebriates.

WE understand that the Normyl Treatment Association is about to open a home, near Sevenoaks, for patients suffering from alcoholism who require special care and supervision. The cost, it is understood, will be kept as low as possible, the members of the Association being pledged to make no personal profits. All inquiries should be addressed to the Hon. Secretary, Normyl Treatment Association, 91, Victoria Street, London, S.W.

Plague in India.

A DISTINCT decrease in the plague mortality is reported from Simla. There were in India during the week ending October 26th only 8,785 deaths, of which 7,034 were in the Bombay Presidency, 203 in the Punjab, 236 in the Central Provinces (including Berar), 589 in Mysore State and 229 in Hyderabad State. The remaining provinces returned even smaller totals. Mr. S. H. Butler, C.I.E., Deputy Commissioner, and chairman of the Lucknow Municipal Board, lately presided over a special meeting of the Municipality to consider measures for rat destruction. A number of the general public were present. It was resolved that an active campaign against rats be declared immediately; that a special staff be employed temporarily for this purpose; that poison be laid down systematically in houses where owners consent, and that house to house action be taken with poison, as well as with traps. "Azoa" poison is to be tried experimentally, and a stock of traps will be kept and distributed, as also leaflets explaining the facilities for rat destruction. Representative ward committees were formed and the co-operation of the public gives every hope that the risk of a serious outbreak of plague this season will be greatly minimised.

Sleeping Sickness—Formation of a Committee.

AN independent Sleeping Sickness Committee has been formed in Liverpool to collect information dealing with Sleeping Sickness, and to stimulate research into the cause, method of transference, and cure of Sleeping Sickness, and to publish from time to time communications with reference to this disease. The following gentlemen are members of the Committee:—Sir Alfred Jones, K.C.M.G. (Chairman); The Rt. Hon. the Lord Mayor of Liverpool (Dr. Richard Caton); Professor B. Moore, Director of the Bio-Chemical Department, Liverpool University; Professor Salvin-Moore, Director of the Cytological Department, Liverpool University; Professor Annett, Director of Comparative Pathology Department, Liverpool University; Professor Sherrington, Director of the Physiological Department, Liverpool University; Dr. Stephens, Walter Myers Lecturer in Tropical Medicine, Liverpool University; Dr. Anton Breinl, Director Runcorn Research Laboratories; Dr. Prout, C.M.G.; Dr. Arthur Evans; Dr. M. Nierenstein; J. W. Garrett, International Fellow, Liverpool University; Dr. J. L. Todd, of Montreal.

Corresponding Secretaries:—Professor Sir Rubert Boyce, F.R.S. (Dean of the Liverpool School of Tropical Medicine), and A. H. Milne, B.A., Cantab.

St. Thomas's Hospital, London.

MR. C. A. R. NITCH, M.S.Lond., F.R.C.S.Eng., has been appointed Surgeon to Out-patients at this Hospital.

THE following gentlemen have been selected as House Officers from Tuesday, December 3rd, 1907:—Casualty Officers:—(Senior) C. M. Page, M.B., B.S.Lond., M.R.C.S.; (Junior) C. E. Whitehead, B.A.Cantab., M.R.C.S. Resident House Physicians:—G. G. Butler, B.A.Cantab., M.R.C.S.; S. L. Walker, B.A., B.C.Cantab., M.R.C.S.; W. H. R. Sutton, B.A., M.B., B.C.Cantab., M.R.C.S.; S. Churchill, M.A., M.B., B.C.Cantab., M.R.C.S.; A. L. Loughborough, M.R.C.S., L.R.C.P. House Physicians to Out-Patients:—B. T. Parsons-Smith, M.B., B.S.Lond., M.R.C.S.; A. J. S. Pinchin, M.B., B.S.Lond., M.R.C.S.; H. B. Weir, B.A.Cantab., M.R.C.S.; R. G. Bingham, M.R.C.S., L.R.C.P. Resident House Surgeons:—H. J. Nightingale, M.B., B.S.Lond., M.R.C.S.; H. R. Unwin, M.A., M.B., B.C.Cantab, M.R.C.S.; G. M. Huggins, M.R.C.S., L.R.C.P.; F. M. Neild, M.B., B.S.Lond., M.R.C.S. House Surgeons to Out-Patients:—H. H. Carleton, B.A., M.B., B.Ch.Oxon.; R. E. Todd, M.B., B.S.Lond., M.R.C.S.; W. R. Bristow, M.B., B.S.Lond., M.R.C.S.; H. E. T. Dawes, B.A.Cantab., M.R.C.S. Obstetric House Physicians:—(Senior) H. B. Whitehouse, M.B., B.S.Lond., M.R.C.S.; (Junior) T. G. Starkey-Smith, M.R.C.S., L.R.C.P. Ophthalmic House Surgeons:—(Senior) A. S. Burgess, M.A. Cantab., M.R.C.S., L.R.C.P.; (Junior) A. I. Cooke, B.A., B.C.Cantab. Throat Department:—A. W. C. Drake, B.A.Cantab., M.R.C.S.; H. N. Little, B.A. Cantab., M.R.C.S. Skin Department:—J. F. Windsor, B.A.Cantab, M.R.C.S.; A. L. Sachs, M.A. Cantab, M.R.C.S. Ear Department:—W. Patey, M.B., B.S.Lond., M.R.C.S.; W. G. H. M. Verdon, B.A.Cantab., M.R.C.S. Children's Surgical:—E. C. Sparrow, M.R.C.S., L.R.C.P. Electrical Department, X-Ray Department:—A. L. Sachs, M.A.Cantab., M.R.C.S.

Royal College of Surgeons in Ireland.

Fellowship Examination.—The following candidates having passed the necessary examination, have been admitted Fellows of the College:—R. Counihan, B.Ch., etc., Univ. Dub.; R. W. Haslett, B.Ch., etc., Roy. Univ. Irel.; D. L. Harding, L.R.C.S.I., etc., Captain R.A.M.C.; M. G. McElligot, L.R.C.S.I., etc., and G. A. Walpole, L.R.C.S.I., etc. The following candidates have passed the primary part of the Fellowship Examination:—H. W. A. Kay, student R.C.P. and S.I.; and T. S. Reddy, L.R.C.S., Edin., etc.

Trinity College, Dublin.

The following candidates passed the Final Medical Examination, Part II., during Michaelmas term, 1907:—Midwifery: Gordon A. Jackson, Johannes C. Pretorius, George B. M'Hutchison, Henry H. Ormsby, George Halpin, Wilfred J. Dunn, William E. Hopkins, Samuel F. A. Charles, Gerald G. Mecredy, Herbert V. Stanley, Dixie P. Clement, Thomas Ryan, Ernest C. Lambkin, William H. Sutcliffe, James R. Yourell, James E. M'Causland.

WHILE a drinking fountain erected at Kettering to the memory of the late Dr. Dryland, for many years medical officer of the town, was being unveiled last Saturday by Admiral Lord Charles Scott, that gentleman gave the rope a too vigorous pull, and the upper part of the fountain came down with a crash.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Herpes facialis in diphtheria.—Rolleston (*Brit. Journ. of Dermatology*, November, 1907) reports the result of his investigation into the frequency of this condition, based on 1,370 cases of true diphtheria under his care during the last five years He found herpes labialis present in fifty-five cases, or 4.01 per cent. Orsi, who analysed 2,400 cases in Mya's clinic, found herpes facialis present in 2.45 per cent. of the cases. Rolleston has found that herpes increased in frequency till the twentieth year of age, and that both sexes were almost equally affected. He also found the condition much more frequently present during the colder months of the year. The occurrence of herpes labialis in over 4 per cent. of cases of diphtheria completely disproves the idea, which was at one time held, that the presence of herpes on the lips was proof that the concomitant angina was not diphtheritic, even though the condition is much more common, 13.1 per cent., in non-diphtheritic angina. Herpes zoster was found in only two of Rolleston's cases. In this respect diphtheria resembles pneumonia. In pneumonia herpes labialis occurs in about 40 per cent. of the cases, but herpes zoster is very rare. Sanné and Baginski both think that the presence of herpes facialis is of no prognostic value in cases of diphtheria, as it occurs equally in the mild and severe cases. Orsi, on the other hand, regards it as a favourable sign, as all but two in his fifty-nine cases recovered. In Rolleston's series of cases the herpes was considerably more common in the severe than in the mild cases. K.

Hæmorrhages in Bright's Disease.—Riesman (*Amer. Journ. Med. Sciences*, November, 1907) discusses the various forms of hæmorrhage which may occur in Bright's disease, and reports two cases in which a true hæmorrhagic diathesis existed. The first was a male, aged thirty years, who had had two previous attacks of nephritis. On admission to hospital it was found that his urine contained 0.15 per cent. of albumen, with numerous granular and hyaline casts and blood corpuscles. Three days later hæmorrhage from the mucous membrane of the mouth set in, and was followed by extensive subcutaneous hæmorrhages. The patient died eleven days after admission to the hospital. The second case was a man, aged 55 years, who had suffered from hæmorrhages for some weeks before admission to hospital. These hæmorrhages continued, and the patient died eight days later from uræmia. Riesman suggests that while ordinary hæmorrhages in nephritis are due to the hypertension and arterial disease, these conditions are not in themselves sufficient to cause the hæmorrhagic diathesis. This condition he attributes to a toxin which resembles the hæmorrhagins of snake venom. Recently Friedeman has found in the pancreatic juice a hæmolysin capable of causing hæmorrhages. This, in normal health, is apparently neutralised by some protective substance, but under certain conditions, among which may be Bright's disease, this protective substance fails to act, and the hæmorrhagic diathesis results. Riesman looks on this complication of nephritis as of particularly bad prognostic significance. K.

Paroxysmal Tachycardia.—Schmoll (*Amer. Journ. Med. Sciences*, November, 1907) based his study of this condition on nine cases which he details, and from which he concludes that the condition is not a single pathological entity. He divides the cases into the following four groups: (1) Cases occurring in patients with a previously damaged heart, (2) cases in patients affected by dysthyreosis, (3) cases in patients exhibiting central nervous lesions, and (4) cases of apparently functional character, the so-called idiopathic group. In the first group the heart lesion alone does not cause the symptom complex, which only originates when a new weakening influence interferes with the action of the heart. In a damaged heart with weak cardiac muscle the slightest provocation may cause an attack, but in fully compensated heart disease an attack does not occur. As regards the second group, Schmoll has seen one case of paroxysmal tachycardia in a patient with adiposis dolorosa, and refers to several observations of cases in which paroxysmal attacks complicated an exophthalmic goitre. Many observations have been recorded in recent years, showing the connection between various lesions of the central nervous system and paroxysmal tachycardia. Thus the condition has been observed in tabes, in multiple sclerosis, in tumour of the brain, and lesion of the medulla oblongata. Schlesinger has observed epilepsy in 25 per cent. of his cases, but all these cases belonged to the symptomatic group of epilepsy caused by anatomical lesions. Schlesinger also records a very interesting case, in which inflammation of the right vagus was discovered post mortem. In this case the attacks could be at once stopped by compression of the right vagus, while compression of the left vagus did not appear to influence the attack. In the fourth group are cases in which no anatomical lesion can be discovered, and which resemble the so-called functional epilepsy to which condition paroxysmal tachycardia has many analogies. The mechanism of the attacks is illustrated by tracings taken during the paroxysms. K.

Diagnosis of Syphilitic Heart Diseases.—Herzog writes on the above subject, and calls attention to the great importance of early diagnosis, though he admits the difficulty presented by these cases (*Berlin Klin. Woch.*, 1907. No. 31). Increased blood pressure accentuated aortic second sound, heaving and diffuse impulse, with irregularity of rhythm, and the pressure of Mussel's phenomenon (nodding of the head synchronous with the pulse) all point to disease of the aortic and coronary arteries, and when there is a syphilitic history, are of special significance. Potassium iodide and mercurials are often of great value in these cases. Another striking characteristic is a rapid development of symptoms, and the appearance of nervous palpitations in patients who are in no way neurasthenic. Aortic insufficiency occurring in middle life, in persons who have no rheumatic history, is also often a syphilitic phenomenon. M.

Erythema Nodosum.—Langford Symes calls attention to the possible infectious nature of this disease (*British Journal of Children's Diseases*, July, 1907). He has lately observed many cases which suggest that such may be the case. Most of those who suffered were together in the same hospital, and he noted multiple cases in houses. The disease set in in every case with pronounced febrile symptoms, and in one case a systolic murmur developed, which however disappeared during convalescence. The writer moreover has at times observed erythema nodosum as a preliminary symptom in cases of meningitis, and therefore believes that it should in all cases be regarded more seriously than is usually the case. M.

Opthalmoscopic Appearances in Vaquez Disease.—Jackson has carefully studied the conditions of the eye in a case of chronic cyanotic polycythæmia (*Opthalmology*, October, 1907). The patient, who suffered from extreme cyanosis, and whose blood count showed the presence of over nine million red cells per c.m., came complaining of blurring of sight, and of epiphora. Examination with the opthalmoscope showed that the dioptic media were clear, but that the retinal veins were large, dark, and tortuous, and about double the size of the arteries, which last-named vessels appeared normal. Later it was found that the pupils were unequal, and did not react well to light, and that some retinal hæmorrhages had appeared. These hæmorrhages were not flame shaped, but were rounded with faintly shaded borders. No white spots were seen, and no other fudal changes. The above observations agree with what has previously been noted in any of these cases that were subjected to proper examination. M.

The Relation of Intestinal Infection to Visceral Tuberculosis.—Whipple, as the result of previously recorded work, has come to the conclusion that the intestinal tract does not play an important rôle as a portal for the entry of tubercle bacilli into the various organs of the body. He now amplifies this work by an analysis of several new cases, and by experiments carried out on animals. He formulates his conclusions as follows: The tubercle bacillus can not pass from the intestine through the lacteals, mesenteric glands, and thoracic duct, into the lungs, without leaving some record of such passage. A few bacilli may, under favourable circumstances, be swept along this course to the lungs, but the majority surely will lodge in the glands, and in time cause a tuberculous process, which can be recognised. When the mesenteric glands are not involved we may exclude the intestinal tract as the portal of entry, but the converse does not hold for the tuberculous mesenteric glands, which may be secondary to some pulmonary forms that are discharging tubercle bacilli into the alimentary tract. The thoracic duct is often the distributing agent in cases that show scattered tubercles in the viscera and tuberculous mesenteric glands.

M.

Treatment of Tuberculous Peritonitis.—Bussi (*Gazz. deg. Ospedali Milan*, September, 1907) relates a number of instances in which he was able to cure the patient by medical measures alone, tapping the effusion and painting the abdomen with iodine and guaiacol, supplemented by hypodermic injection of a solution of 1 gm. of iodine to 10 gm. potassium iodide, with 20 gm. guaiacol and 80 gm. glycerine; in some cases an iodised gelatine preparation was given by the mouth later. The results were good in all the cases related. He ascribes almost a specific action to iodine in tuberculous affections. In one severe case recovery followed tapping and insufflation of heated air into the abdominal cavity, supplemented by a compressing bandage and administration of iodised gelatine. In another very severe case, in a girl of 16, no benefit was derived from medical measures, and the peritoneum was drained and wiped dry. Typical tuberculous granulations were found disseminated over the peritoneum and intestines. After the abdomen was sutured the iodine and guaiacol applications were resumed, with prompt recovery to date, a year later.

D.

Treatment of Acute Articular Rheumatism with Constriction Hyperæmia.—Steinitz (*Zeib. f. Klin. Med. Berlin*, 1907) reports his experiences with 175 patients treated by constriction hyperæmia with and without the salicylates. The application of the constricting band almost invariably relieved the pain. A large number of patients recovered in from 4 to 20 days, as early as those treated with the salicylates. Even if the Bier treatment fails to cure, it can scarcely ever do harm. Complications seemed less frequent and milder than under exclusive salicylic medication. High temperature does not contra-indicate it. In case moderate temperature persists unmodified after the fifth day under the Bier treatment, he advises giving salicylates, as also when the affection changes rapidly from joint to joint. In cases of recent endocarditis, he advises restricting the salicylates as much as possible and relying mainly on the constricting band. D.

Hysterical Sweating.—Curschman (*Mün. Med. Woch.*, September, 1907) reports two cases of long-continued periodic sweating in a mother and daughter. They appeared two or three times daily, were of a drenching character, unaccompanied by chill or by fever, and without any preceding hysterical manifestations (convulsions, etc.). During the attack the mind was clear, the patient quiet and peaceful, no preceding embarrassment or excitement was demonstrable. The sweats presented the picture of those resulting from the use of diaphoretics. Blood pressure and frequency of pulse were never increased. No organic changes in the central nervous system could be made out. Treatment by suggestion proved promptly effective in both cases. The author considers the etiology to have been hysterical. He has found no similar cases reported in the literature. D.

Apomorphin in Diagnosis of Bulbar Affections.—Ferreira (*Presse Med. Paris*, September, 1907) announces that a weak or negative response to a small test injection of apomorphin will reveal bulbar paresis before it is clinically manifested. Glossolabial-laryngeal paralysis can thus be detected in its incipiency by the degree of nausea and the amount of vomiting. If there is no vomiting at all, the medulla oblongata is already seriously affected. D.

Nasal Origin of Lupus of Face.—Caboche (*Presse Med. Paris*, October, 1907) presents an array of evidence to sustain his assertion that lupus of the face, in nearly every case, is the result of the propagation to the skin, by way of the lymphatics, of a lupous lesion on the nasal mucosa. Treatment of the latter alone is sometimes followed by the retrogression of the superficial lupus, and inversely if the latter is treated alone, there is liable to be re-inoculation from the nasal lesion. D.

Diagnosis and Treatment of Tuberculous Skin Affections.—Nagelschmidt (*Deut. Med. Woch.*, Berlin, October, 1907) relates that a drop of tuberculin inoculated into a tuberculous lesion of the skin causes ulceration. Inoculation of sound skin causes the development of a papule, but no ulceration. He has found this an excellent means of determining whether a lupous patch has entirely healed under Finsen treatment, or whether there are still some points left, especially those embedded in cicatricial tissue which it is difficult for the Finsen rays to reach. The inoculation has not only diagnostic value, but also a direct curative action, as the nodules heal definitely under the influence of the transient ulceration. Minimal quantities of tuberculin suffice for the reaction. He deposits two or three drops of tuberculin around the lesion, and scrapes the skin between them. After 15 or 20 seconds he wipes off the tuberculin without touching the excoriated part. This avoids absorption of superfluous tuberculin, and prevents any general reaction. Sometimes he injects a drop of tuberculin directly into the nodule. He commends this local tuberculin treatment for lupus when Finsen treatment is not accessible, especially for isolated foci, also for differentiation of tuberculous cutaneous affections, and as supplementary to other methods of treatment. Its drawbacks are the loss of substance left by the ulceration and the liability to a general reaction if too much tuberculin is absorbed. D.

Gift for Cripples.

At a meeting in connection with the Birmingham Crippled Children's Union on November 23, a communication from Mr. George Cadbury, offering the Woodlands, a large residence standing in four acres of ground at Northfield, as a convalescent home for child cripples, was considered. A resolution was passed accepting the gift, and thanking Mr. Cadbury for his munificence. It was stated that the house, which contains fifty rooms, had been inspected by the medical officers of the Union, who were entirely satisfied as to its suitability for the purpose to which it is now to be devoted. It will accommodate forty children. The site adjoins the Bournville Village Trust property, so that the maintenance of healthy surroundings is assured. It is in contemplation to hand the Woodlands over to the Birmingham Corporation, but this is left to the discretion of the committee of the Crippled Children's Union.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Post-Graduate (London).—In all cases of malignant disease the blood should be examined as a matter of routine. But upon this point our correspondent had better communicate with Dr. John A. Shaw-Mackenzie, who, no doubt, would supply all the information required. Dr. Shaw-Mackenzie was the first to show the value of this method of examination in cases of the kind.

X. Y. Z.—The case is obviously one in which the medical man concerned should be summoned to give evidence. But coroners in rural districts are often disposed to ignore this necessary detail, presumably for the purpose of saving the fees.

Tu quoque.—We have carefully considered our correspondent's communication, and our advice to him is to leave the matter alone.

ANATOMICAL QUESTIONS AND ANSWERS.

The Professor: Some of you gentlemen are not giving me your closest attention. Mr. Biggs, what do we find under the kidneys?

Future M.D.: Toast, sir.

Dr. Gaskell.—The expression "courir comme un derate" is derived from the belief (founded, we are assured, on actual practice) that persons whose spleen has been removed are able to run better than their brethren who are still burdened with this viscus. The operation is not a recognised surgical procedure, at any rate, for purely athletic purposes.

M. R. F.—Bier's method of treatment by provoking a determination of blood to, or its stasis in, a given part is applicable to boils and carbuncles, and gives very good results. In a sense, of course, the historical practice of sucking a poisoned wound may be said to act somewhat in the same way, though the action must be in a measure mechanical, the blood washing away the poison.

Dr. Lionel Tayler.—Your letter has been forwarded to "Paterfamilias Medicus" for reply.

Meetings of the Societies, Lectures, &c.

Wednesday, December 4th.

Royal Society of Medicine (Neurological Section) (20 Hanover Square, W.).—8.30 p.m.: Papers:—Dr. J. S. Collins: On Certain Peculiarities of Intra-cranial Gummata.—Dr. F. E. Batten and Dr. G. Holmes: Nervous System of a Dog with Ataxia. Dr. T. G. Stewart: Four Cases of Tumour of the Fourth Ventricle.—Dr. E. F. Buzzard: Case of Tubercle of the Sixth Nucleus.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. C. Ryall: Clinique. (Surgical.) 5.15 p.m.: Lecture.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Thursday, December 5th.

North-East London Clinical Society (Prince of Wales's Hospital, Tottenham, N.).—4.15 p.m.: Clinical Cases.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. J. Berry: The Treatment of Hip Disease in its Later Stages.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel).

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Fungous Diseases of the Hair: I., Hyphogenic Sycosis; II., Tinea.

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Batten: The Treatment of Infantile Paralysis.

Friday, December 6th.

Royal Society of Medicine (Laryngological Section) (20 Hanover Square, W.).—5 p.m.: Cases and Specimens will be exhibited by Dr. C. Potter, Dr. J. Horne, Mr. A. Evans, Mr. H. Tilley, and Mr. H. Barwell.

West Kent Medico-Chirurgical Society (Miller Hospital, Greenwich, S.E.).—8.45 p.m.: Purvis Oration: Dr. R. Russell: The Diagnosis of Organic from Functional Affections of the Nervous System. Conversazione.

West London Medico-Chirurgical Society (West London Hospital, Hammersmith Road, W.).—8.30 p.m.: Papers:—Dr. M. Moullin: Treatment of Uterine Fibroids.—Mr. S. Headley: Chronic Appendicitis in Women.

Child Study Society (Parkes Museum, Margaret Street, W.).—8 p.m.: Lecture:—Prof. J. Edgar: Imitation and Individuality in Children.

Society of Anæsthetists (20 Hanover Square, W.).—8.30 p.m.: Paper:—Dr. W. J. McCardie: Status Lymphaticus. Adjourned Discussion on Mr. H. Hilliard's paper.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. R. Lake: Clinique. (Ear.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Saturday, December 7th.

Royal Society of Medicine (Otological Section) (20 Hanover Square, W.).—10 a.m.: Cases, etc., will be shown by Mr. S. Scott, Mr. A. H. Cheatle, Mr. H. Tod, Mr. R. Lake, Mr. M. Yearsley, Dr. W. Milligan, Mr. L. A. Lawrence, and Dr. W. H. Kelson.

Appointments.

McRae, G. Douglas, M.D., F.R.C.P.E., has been appointed Medical Superintendent to the Ayr District Asylum.

Bunch, J. L., M.D., B.S.Lond., Physician in Charge of the Skin Department at the North-Eastern Hospital for Children.

Clarke, H. M., M.B., B.C.Camb., Clinical Assistant to St. John's Hospital for Diseases of the Skin.

Friend, G. E., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Chelsea Hospital for Women.

Griffith, T. Wardrop, M.D.Aberd., Honorary Consulting Physician to the Leeds Public Dispensary.

Michie, W. A., M.D.Aberd., M.R.C.S.Eng., Clinical Assistant to St. John's Hospital for Diseases of the Skin.

Morton, John, M.B., M.S.Glasg., Clinical Assistant to the Chelsea Hospital for Women.

Tylecote, F. E., M.D.Vict., M.R.C.P.Lond., Clinical Assistant to St. John's Hospital for Diseases of the Skin.

Vacancies.

Seamen's Hospital Society, Greenwich, S.E.—Medical Superintendent of the Dreadnought Hospital, Greenwich. Salary £200 per annum, with board in the Hospital. Applications to P. Michelli, Secretary.

University of Manchester.—Senior Demonstrator in Physiology. Salary, £150 per annum. Applications to the Registrar.

Bristol General Hospital.—Senior House Surgeon. Salary, £120 per annum, with board, residence, etc. Applications to the Secretary.

Manchester Hospital for Consumption and Diseases of the Throat and Chest.—Resident Medical Officer. Salary, £100 per annum, with board, apartments, washing, and railway contract. Applications to C. W. Hunt, Secretary, Hardman Street, Deansgate, Manchester.

Wandsworth Union Infirmary, St. John's Hill, near Clapham Junction.—Junior Assistant Medical Officer. Salary, £100 a year, board, lodging, and washing. Applications to the Medical Superintendent.

The Homes for Little Boys, Farningham and Swanley, Kent.—Medical Officer. Salary, £100 per annum, with board, residence, and laundry provided. Applications to Percy Roberts, Secretary, Homes for Little Boys, 100, Temple Chambers, Temple Avenue, E.C.

Births.

Gavin.—On Nov. 26th, at 61, Biddulph Mansions, Elgin Avenue, London, Evelyn, the wife of A. C. Gavin, M.B., of a son.

Tebb.—On Nov. 25th, at 226, Finchley Road, Hampstead, Bertha Mary, the wife of Albert Edward Tebb, M.D., of a son.

Marriages.

Burleigh—Wallace.—On Nov. 20th, at Glasgow, James Seath Burleigh to Edith Christine Wallace, M.D., daughter of the Rev. James Wallace, Church of Scotland, Glasgow.

Robertson—Tooley.—On Nov. 28th, at Mombasa Cathedral. East Africa, Alexander Robertson, M.B., C.H.B., D.S.H., of Elgin, N.B., to Gertrude Emilie, third daughter of Mark Tooley, Esq., Denmark Hill, London.

Deaths.

Hooper.—On Nov. 24th, at 9, Trinity Square, Borough, Daniel Hooper, B.A., M.B., London, for many years physician to the Surrey and Clare Market Dispensaries, in the 85th year of his age.

Laird.—On Nov. 27th, at 58, Salcott Road, Wandsworth Common, Elizabeth Ann Laird, widow of the late James Laird, M.D., R.N., aged 82 years.

Porter.—On Nov. 27th, at Salisbury Road, Southsea, Mary J. R. Porter, widow of Surgeon-Major J. H. Porter, A.M.D.

Woodford.—On Nov. 27th, at 67, Eardley Crescent, London, Jessie Jane, widow of the late C. T. O. Woodford (M.D., F.R.C.S.London), of Calcutta, aged 75.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, DEC. 11, 1907. No. 24.

NOTES AND COMMENTS.

G.M.C. and Penal Powers.

THE recent proceedings of the General Medical Council meeting bring out into relief the fact, which has long been patent to those interested in the doings of the Council, that that body is badly equipped in the matter of penal powers. It has, in fact, but one power, namely, that of striking a medical man off the Register. So inelastic and clumsy is this instrument of discipline, that in course of time the Council have evolved various devices for using it with less than full force. For instance, a culprit in whose case there are extenuating circumstances may be told that judgment will be delivered next session, a course which gives him the opportunity of reform in the meanwhile; or an accused may be summoned to appear in person before the Council, a course which may mean the loss of some days' work and a good many incidental expenses. But, still the point remains that the inability to mete out different specific degrees of punishment is a serious handicap to the administration of justice and the maintenance of discipline. It is a gross anomaly that the man who has been convicted of procuring criminal abortion and a man who has been fined five shillings for a trivial offence should both be subjected, or be liable to be subjected, to the same penalty, namely, striking off the Register. It will be argued that serious crimes are dealt with by the law, and therefore the General Medical Council merely has to strike offenders automatically off the list after their conviction, but the point remains that in any future Bill dealing with the Council the power should be sought for ability to grade penalties. A power to fine a medical man £50 or £100 would be most useful in the case of civil offences of a minor character, and would not be so severe a punishment as completely striking him off the Register.

Value of Representation.

IN the present state of the law at any rate, everything should be done which can properly be done to keep a man on the Register, because while he is still there he is under some kind of discipline and control, whereas if he be struck off, as likely as not he has no alternative to his profession whereby to earn his living, and his uncontrolled practice goes on. On the other hand, if the Council had power to impose a heavy fine, and to repeat it if necessary, the proper conduct of the offender's practice would be more effectively ensured. Diversified powers of this kind are badly needed, and now that the Council are beginning to awaken to the fact that there is a body of men called general practitioners which has many grievances and trials, we hope they will seriously set themselves to work to think how they may best reform their own constitution and powers. The fresh blood infused into their veins by the new direct representatives has had an oxygenating effect already, and the rank and file of the profession will not be slow to recognise the result and the credit its authors deserve. Perhaps in the future, when the General Medical Council is like that of other professional bodies, namely, representative of the profession it is supposed to represent, it might be possible to affect the members directly by the feelings and opinions current at the time.

Anti-Quackery Legislation in New Zealand.

THE Bill for the prevention of quackery in New Zealand is before the House of Representatives, and has reached a very exciting stage, namely, that which follows the report of a Parliamentary Committee. It will be remembered that the Bill was violently opposed not only by the traders in quack drugs, but by the newspaper interest generally. Indeed, the storm raised by the latter threatened to engulph the infant at its birth. However, so far it has survived, although the Committee have toned it down a good deal, in form at any rate. The gist of the matter is the disclosure of the formula, which, of course, is diametrically opposed to the interests of the trade, because not only are the formulae of these preparations utterly devoid of originality, but they command their sale by working on the awe and superstition of people. The committee have given in on this point to the extent of providing that a formula need not be disclosed if it is original, and the proprietors can satisfy the High Court that it is not fraudulent or harmful, that it is by way of doing what it claims to do, and that it may with safety be entrusted to inexperienced and uninformed persons for the purpose of self-treatment.

Further Recommendations.

IF the authority to which reference as to the character of the preparation is to be made had been the medical council of the Colony, which should surely be better able to form an opinion on the effect of drugs than the High Court, this proviso would not be very much of a hindrance to good administration, but it is obviously a great experiment to make the High Court the arbiter, for the questions raised would not be legal in any sense, and no one can predict how they would present themselves to a lawyer's mind. Still, on the whole, the provision ought not to spoil the Bill, for even if it did not work quite equitably in practice, there are other valuable provisions, such as that measures should be taken to stop the sale and advertisement of all preparations and medicines which do not comply with the regulations just mentioned. The committee urge the Government to put the matter through this session, and we hope indeed they will If the measure can be carried now while the ma is alive it will have far more effect than if it is allowed to drivel through session after session, continually being watered down by the trade and the papers. Now, if New Zealand carries this legislation through, we take it that three-quarters of the patent medicine trade will be done away with, and that the quarter that remains will be emasculated, so far as its powers for harming people are concerned. New Zealand, too, is the most democratic country in the world, and it is a bitter lesson of the power of interest over the good of the community that all the advantages of experience and intellect which the mother country enjoys do not enable her to tackle a simple question of this type.

"The School of Brutality."

THE unfortunate incidents connected with the "Brown Dog" have had the effect which we feared, namely, the opening of the vials of antivivisection vituperation on medical students. Under the title of "The School of Brutality," Miss Lind-af-Hageby, the lady whose incorrect statements—to use the language of courtesy—let Mr. Coleridge in for his slander action and an adverse verdict of £2,000, has published a collection of cuttings about the disturbances, preceded by a waspish introduction by herself. This is being circulated with the announcement of a lecture by herself on "Vivisection and Medical Students," and therefore it may be guessed what the character of the lecture will be. Miss Hageby, having laid the train, lighted the fuse, and seen the building explode, now has the exquisite pleasure of talking to her friends and rubbing her hands over the effects of the explosion. We hope that in common honesty Miss Hageby will explain the part she took in igniting the flames and the mechanism of the Coleridge action.

Drink "Cures."

A SIGNIFICANT light was thrown on the composition of the Royal Commission on Quackery—when it does come, as come it must sooner or later—by the reply made by the Home Secretary to a temperance deputation that waited on him the other day. Mr. Gladstone said that he recognised that the 1898 Act for controlling inebriety had been to a great extent a failure, and that he would appoint a departmental committee to inquire into the question of inebriety and narcomania. In the meantime he would await the report of the Royal Commission on Feeble-mindedness, which is shortly to be issued, because it will contain a large amount of evidence as to drunkenness, and certain recommendations for legislation might be made. He then proceeded to discuss the composition of the Departmental Committee, and expressed the opinion that the medical element should be adequate, but subordinate to the lay. Mr. Gladstone indicated that drink "cures" would be one of the matters specifically referred to the committee, because of the number that have appeared on the market of late, and the interest shown by the public in them. Now, we should have thought that in a matter so technical as this medical men would have been the only people whose opinion was worth having, and that if laymen were appointed they should be but few proportionately. However, the view of the Home Office is different, and they have the deciding voice. At any rate, we offer a warm welcome to such an inquiry.

LEADING ARTICLES.

LONDON UNIVERSITY CRISIS.

IT is now almost a hundred years since the University of London entered on the most chequered career that ever University pursued. Almost from its birth the academical institution of the hub of the Empire has been in the throes of construction or reconstruction, with the result that after a century of tinkering it remains a monument of the inefficiency of Londoners to manage educational affairs. If the cause of the fiasco be sought, it will be found to consist of several complex factors, such for instance as a lack of civic patriotism in Londoners, in a contempt for education which distinguishes many commercial minds, and above all perhaps, in a want of idealism. Still, there is no gainsaying the fact that the University of London is as little interwoven with London life as is the University of Brussels. This aloofness is found not only in medicine, indeed perhaps is seen less in medicine than in any other faculty, but is to be found in arts, science, law, and music. Indeed, the London University, instead of being an expression of the civic ardour for culture, is like the "foreign garrison" in Ireland, a kind of extraneous authority placed over the heads of the natives to see that too much freedom and independence does not exhibit itself. We have only to compare these university methods with those in Scotland to see exactly where failure occurs. In Scotland the elementary school lad, if he is able to go on with his studies, passes naturally to the intermediate school, and from the intermediate school to the university, where after an average career he finds himself M.A. in two or three years. That is to say, the university caters for the average man, provides him with his progressive scale and the means to mount it, and ends by conferring on him the *cachet* of M.A., because that degree is a commercial asset wherever he goes for a job. The London University takes no notice of its students till they come to it, and then insists on their passing an examination which would pretty nearly win them a university degree in Scotland. Although London has lately assumed teaching functions, these are yet pretty far divorced from the examining ones, which remain the prime object of the system. The students are sent up for exceedingly difficult examinations, and a comparatively small proportion are passed; whilst it has been recognised for years that the examinations are "tricky." Indeed, when the object of an examination is rather to keep candidates from a degree than to provide a gateway to it, the "tricky" element is bound to appear. The consequence of this throttling policy is that the London University is an ogre to London students instead being the friend that helps to success, and it is distinctly understood that the desire of the authorities is that only a small proportion of the students are to be eventually successful in graduating. Now, this same principle holds good in the London University attitude towards medical students. Instead of all students going in for the London M.D., and about 75 per cent. being successful, about 30 per cent. or so go in, and about 15 per cent. or so eventually attain it. The London University may, and does, demand a high standard for its degrees, but as a University for London it has completely failed. It is a mere geographical accident that it happens to be situated in the Metropolis. The last scene of all in this strange, eventful history is the recent ruination of the work of that band of devoted reformers who, largely under the inspiration of Dr. Kingston Fowler, nearly succeeded seven years ago in adapting the university to the needs of the teeming millions in London. The work we are specially concerned with is that of medical education. When the university was reconstructed in 1900, and "internal" students created, it was obvious, not only for the sake of economy for the medical schools but for the creation of the "University" idea, that a centre of teaching should be established. The elementary medical subjects needed such united teaching, schemes was made out and approved, funds were appealed for and in part promised, a splendid site was granted, and everything was ready for the university to go ahead, when the old prejudices, prepossessions and vested interests, surged into force again, and the scheme was defeated. The Senate of the University has consequently given up the site, and purposes to send the money back to the donors, and the hands of the clock are put back for another twenty or thirty years. The history of the London University is a string of ineptitudes, of which the last item is perhaps the greatest. Londoners and lovers of culture can only hope that God does not slay all those whom he drives mad.

CURRENT TOPICS.

Mountain Sickness.

DR. W. H. WORKMAN, in the course of a lecture recently delivered before the Royal Geographical Society, gave an interesting account of his climbing experiences in the Nun Kun group in Kashmir. He dealt particularly with the glaciers, and notably with the *niveos penetrantes*, which he met with for the first time in five seasons of Himalayan exploration. An interesting part of his paper to all mountaineers is that connected with mountain sickness. Dr. and Mrs. Workman stayed one night alone at a camp 21,300ft. above sea level, the highest point, up to the present, at which mountaineers had passed the night. There were nine Europeans—a guide and six porters, with the two heads of the expedition —and only one porter really suffered from mountain sickness. "Although complaining of headache and weakness," said Dr. Workman, "at the third camp (20,632ft.), he started to go to the fourth with a light load of instruments, but was unable to keep up with the rest of us, and soon fell behind, showing unmistakable signs of mountain sickness. Before reaching an altitude of 21,000ft., though naturally a strong and healthy man, he collapsed entirely and became helpless. He complained of loss of sensation in his hands. His woollen mittens being drawn off, his fingers were found white and stiff, and if not already frostbitten on the point of becoming so. Vigorous rubbing and pounding of his hands finally restored circulation, when he was sent down to the third camp. The fact that his hands, even when protected by thick woollen mittens, were brought by the cold to the verge of frostbite, while my own, without any covering, were comfortably warm, shows how profoundly the circulation and vitality are prostrated by mountain sickness, and how dangerous it is for one suffering from this malady to be exposed to the cold of high altitudes." None of the other members of the party were incapacitated, but, said Dr. Workman further, "Every one, as was to be expected, felt the effect of altitude on the respiration, though some to a greater extent than the others. This, as is usual, manifested itself by shortness of breath and panting on slight exertion. In the erect position, when resting, the respiratory disturbance was not so noticeable, being marked only on movement, but at night on lying down it became more urgent, being accompanied by a feeling of oppression, for the relief of which a number of deep inspirations were necessary. The frequent repetition of these wearied the respiratory muscles and even became painful. During the five nights at our three highest camps no one obtained more than a few snatches of sleep, and four, of whom I was one, practically none at all. It is scarcely necessary to say that even the strongest could not hold out for long against the depressing influence of loss of sleep, combined with the lowering of vital energy due to the scarcity of oxygen at these high altitudes."

Candour between Physician and Patient.

IN an address to the Medical Society of the State of New York, a week or two ago, ex-President Cleveland put in a plea for greater candour on the part of the medical attendant toward his patient. According to Mr. Cleveland, a critic friendly to the profession, the medical man still likes to maintain a certain air of mystery as to the means by which he works, and is loath to give the patient any information as to the methods employed in curing his disease. In the past there certainly was this tendency on the part of the physician, who cloaked his ignorance in learned words, and others beside Mr. Cleveland charge us with it at present. There is no doubt that in all cases there should be perfect frankness so far as the intelligence of the patient will permit, and it is astonishing how much further this is than many medical men imagine. Moreover, in many cases the curative effect of the physician's labours may be materially increased by obtaining the intelligent co-operation of the patient. The physician should proceed, not by Eddyist hocus-pocus, but by measures whose rationale he should be able and eager to explain.

Victory at Cheltenham.

WE have had occasion before to refer to the case of Dr. J. H. Garrett, Medical Officer of Health for Cheltenham, whose services a section of the Council of that town proposed to reduce from £600 to £500 a year. Last week the matter came before the Town Council, the Health Committee bringing forward a report against the decrease in reply to one in its favour presented by the Expenditure Inquiry Committee. Alderman Norman, who moved the adoption of the Public Health Committee's report, said that probably the Council were unaware that the Local Government Board had controlling power in that matter, and that it was exceedingly improbable that they would consent to the decrease, as £500 was the minimum recognised by the Board for a town of the size of Cheltenham, and, moreover, that Dr. Garrett had put in six years' good service since the increase was granted. Alderman Skillicorne, who moved an amendment, said that

Dr. Garrett had "insulted" members of the Council, and that if they did not decrease his salary they would be laying themselves open to be similarly insulted by all their officers. Now, Dr. Garrett had previously shown that the "insult" consisted in putting a wrong interpretation on his words, and it seems that the councillors who felt themselves insulted must have had very tender consciences. The Health Committee, who were certainly in the best position to judge of Dr. Garrett's work, were in his favour; and a medical member of the Council said that no sort of case had been made out for reducing the salary, but that the Inquiry Committee, failing to find anything wrong anywhere else in the various departments, pitched on the medical officer's salary. When it came to voting, the amendment was only defeated by the narrow margin of eleven votes to ten, and the Health Committee's report was adopted by a majority of twelve to nine. We sincerely congratulate Dr. Garrett on his well-earned success. Fortunately, matters at Cheltenham did not come to the pitch they arrived at at Southend, but they were near enough to be uncomfortable. At any rate, the same solidarity might have been looked for in the profession if the crisis had been brought about.

Town Water Supplies.

The rapid growth of the great centres of population renders the problem of the national water supply one of increasing difficulty. Many of the rivers have been drawn upon to the extent of their capacity consistent with the maintenance of their own streams. Moreover, as the rural and provincial density increases, the inevitable resulting pollution of rivers makes them more and more undesirable for potable purposes, so that the cities are driven to the great watersheds and mountainous districts for their supplies. The whole question, so far as London is concerned, must became a matter of urgency before many years have passed away. The Metropolitan Water Board is at present discussing the momentous question as to the desirability of securing an additional water supply for Londoners, "after increased supplies from the Thames are no longer economically available." Sooner or later it seems probable that they will have to resort to the Welsh mountains for their catchment area. The *Standard* has advocated the widening of their scheme of operations so as to secure a national basis. There is a good deal to be said in favour of that proposal, for water is just as much a necessity of life as air or earth. So long ago as 1869 the Royal Commission, presided over by the Duke of Richmond and Gordon, recognised the necessity of parliamentary interference in order to prevent the selfish appropriation of watersheds by local authorities. It is tolerably clear that Londoners have been caught napping, and have been to a great measure forestalled in the matter of the Welsh hills. Under any circumstances, however, it is unlikely that a more enlightened generation will consent to drink river water that has been extensively polluted with sewage.

Civilian Doctors and Army Medical Training.

We are informed by the War Office that, in order to utilise the valuable clinical field provided by the Queen Alexandra's Military Hospital, the Army Council have decided to associate that hospital with the Royal Army Medical College, as an integral part of its medical school, for the purpose of furthering the earlier and advanced education of officers of the Royal Army Medical Corps. They have further decided to obtain the assistance of certain prominent members of the medical profession as consultants in medicine and surgery, whose professional skill will conduce to the efficiency of the hospitals as regards both the treatment of the sick and the investigation of the various diseases incidental to military life. These appointments will have the further effect of fostering among the civil members of the profession a greater interest in the work of the Army Medical Service, and in those special problems with which its officers have to deal.

The following appointments have been approved:

To be Consulting Surgeons:—

A. E. Barker, Esq., F.R.C.S., Professor of Surgery, University College of London.

A. A. Bowlby, Esq., C.M.G., F.R.C.S., Surgeon to St. Bartholomew's Hospital; and

G. H. Makins, Esq., C.B., F.R.C.S., Surgeon to St. Thomas's Hospital.

To be Consulting Physicians:—

Dr. J. Mitchell Bruce, F.R.C.P., Consulting Physician Charing Cross Hospital.

Dr. J. Kingston Fowler, F.R.C.P., Physician to Middlesex Hospital.

Dr. W. Osler, F.R.S., F.R.C.P., Regius Professor of Medicine, University of Oxford.

Medical Examination of Children for Factory Work.

A school attendance officer has written a pertinent letter to the *Manchester Guardian* on the medical examination to which children and young persons are subjected before being permitted to enter the factory or workshop. The journal in question makes some sensible comments on the communication, and endorses generally the sceptical attitude of its correspondent. Out of 700 children who have in the latter's experience been allowed by the education authorities certificates of practical and complete exemption from school attendance, only one, to his knowledge, has been declared fit by the certifying surgeon to work in the mill. Obviously, if these children were unfit to attend school, they were not proper candidates for factory life. The last report of the Chief Factory Inspector shows that, out of a total of 390,829 examinations, there were only 3,257 rejected on medical grounds, or three-quarters per cent., a result that certainly does not justify the pessimists who talk in so dejected a way about our physical degeneration as a nation. In 1906 only 800 conditional certificates were given—that is to say, restricting the child to certain occupations. It is hard to think that out of 390,829 children all except 800 were fitted for all and every kind of work. Among the 800, moreover, were cases of infantile paralysis, hip and spinal disease, epilepsy, heart disease, phthisis, bronchitis, and scrofula. It is no excuse for the certifying surgeons that the fee for examination is absurdly inadequate, and that in the case of rejection their reasons must be stated in writing. If the duty be accepted by the certifying surgeons, it should clearly be performed with a full sense of responsibil[illegible]y. On the other hand, it is clear that a rigid examination and a high standard would make demands upon the surgeon's time out of all proportion to the emoluments. If the Government of this country are in earnest in their desire to exclude diseased and feeble children from our factories and workshops, they will do well to attend to this serious defect in industrial legislation.

The Irish University Question.

The most important announcement on this subject was made on Thursday last at Manchester, when the Provost of Trinity College announced that he had received positive assurances from Mr Birrell that, in the proposals which he hopes to lay before Parliament, Trinity College, its constitution, and its endowments are absolutely excluded. The Provost further announced that the governing body of Trinity College would be prepared to give Mr. Birrell every assistance in their power in working out any scheme for the real good of the country. We cordially congratulate both Mr. Birrell and the Provost, the former because he has decided to work in the path of the least resistance, rather than in that of the greatest resistance, the latter because a great danger to the institution over which he presides has been averted. It was a foolish policy which led Mr. Birrell's successor to try to begin his work by felling mighty oaks across the path which he must travel to reach his end, and now that such a policy has been abandoned it is to be sincerely hoped that head-way will be made. To judge from a further statement made by the Provost, it would appear that the general lines along which Mr. Birrell intends to work are similar to those at which we have already hinted in these columns. Thus, there may be a revival in Belfast of the old Queen's University, which will have an "atmosphere" of its own decided by the majority of its students, while the remaining three Colleges will be united with another University, which will also have an "atmosphere" of its own. Like Sir Edward Carson, we prefer to see Mr. Birrell's new Bill before we express an opinion thereon, but it should follow the lines at which the Provost hints. It will, at any rate, start with a far greater prospect of success than did Mr. Bryce's happily defunct scheme.

The Nature of the Soul.

When Descartes thought fit, nearly three hundred years ago, to publish his "Discourse," in which, among other topics, he treated of the location of the soul, he was subjected to a certain amount of opprobrium in that he chose to appeal to the ignorant rather than to the learned, by couching his reasonings in the vulgar tongue. It is, therefore, in good company that Dr. Albert Wilson, "who is shortly publishing the result of his researches into the brain, which he has been carrying on for the last twenty years," addresses himself first to the unlearned, and makes the earliest disclosure of his results, not through the medium of one of the scientific journals, but in the columns of *Black and White*. He has, doubtless, been wise in his choice. Moreover, like a discreet man of business, Dr. Wilson discloses so little of the secrets he has discovered that all his readers are left agog for more information. We are told that his researches "have helped to demonstrate both the existence of the soul and the possibility and probability of its existence after death." The soul, we are told, "is a superstructure of the mind"; and the mind, being a superstructure of the brain, if not, as is suggested, the cortical layer itself, we are led to the conclusion that the soul is a superstructure on a superstructure, which, nevertheless, can exist after the disappearance of its foundation, the brain. Dr. Wilson's researches are rich in practical as well as theoretical points of interest. For instance, the "pre-frontal arc of the brain" is the seat of control, which can be put out of action by alcohol. Our whole prison system, too, is wrong, as, to quote Dr. Wilson's own words, "The antiquated law methods of so much punishment for so much crime is too fossilised to deserve any toleration." No more, alas! must the punishment fit the crime. Mr. Bernard Shaw tells us that what the poor suffer from is poverty. Not so Dr. Wilson; he finds that they suffer from deficient brain-cortex, "due to the destructive influence of enforced education."

PERSONAL.

H.R.H. Princess Christian of Schleswig-Holstein opened the new operating theatres and anæsthetising rooms at the Royal Free Hospital on December 3rd.

Mr. Francis Reckitt has given a donation of £10,000 to the Great Northern Central Hospital.

Professor Landouzy has been selected for the post of Dean to the Faculty of Medicine at Paris, in place of M. Debove (resigned).

In memory of Professor Pirogoff, the Moscow Town Council propose to name a street after him, and triennially to award a prize of £60 value for a work on Surgery.

It is announced that Professor Ronald Ross is to be invited to accept the post of Physician to the Ward for Tropical Diseases lately established at the Royal Southern Hospital, Liverpool.

The annual Bradshaw lecture was delivered before the Royal College of Surgeons on Friday last by Mr. Rickman J. Godlee, vice-president of the college and surgeon in ordinary to the King.

Brigade-Surg.-Lieut.-Col. David D. Cunningham, C.I.E., I.M.S. (retired), has been appointed Honorary Physician to the King, vice Surgeon-General Sir J. Fayrer, Bart., K.C.S.I., deceased.

Dr. E. M. Grace, the cricketer and coroner, has resigned his position as District Medical Officer and Medical Officer to the Workhouse of Thornbury, Gloucestershire, after forty years' service.

We understand that Dr. William Carter, Senior Physician, and Mr. William Alexander, Senior Surgeon, propose shortly to retire from the active staff of the Royal Southern Hospital, Liverpool.

A marble bust of Dr. Huglings Jackson has been presented to the National Hospital for the Paralysed and Epileptic, Queen's Square, W.C., in recognition of his distinguished services to neurology.

Surg.-Gen. Sir Alfred Keogh, Director-General, gave a dinner at the Royal Army Medical College, Millbank, on the 27th ult., to which guests representative of the War Office and the General Medical Council were invited.

A CLINICAL LECTURE

ON

"OTOSCLEROSIS." (a)

By MACLEOD YEARSLEY, F.R.C.S.,

Senior Surgeon to the Royal Ear Hospital.

GENTLEMEN,—The condition to which the name, "otosclerosis," has been applied is one of which the morbid anatomy has been worked out only comparatively recently, and there is still much to be learned as to its real significance, and, still more, as to the best means of combating its insidious onset.

The term "otosclerosis" is a misleading one, both from the point of view of the morbid anatomy and from the fact that it has led to some confusion between it and the post-catarrhal changes which form the latest stages of catarrhal inflammation of the middle ear. Strictly speaking, it is not a middle ear process at all, but is essentially an affection of the labyrinthine capsule. It is characterised by a bony ankylosis of the stapes in the fenestra ovalis, together with osteophytic outgrowths in the lower parts of the scalæ tympani and vestibule, and in the fossula ovalis, and often with isolated spots of osteoporosis in the bony labyrinthine wall. The membrana tympani is normal, or approximately so, and the Eustachian tubes retain their patency.

The most important changes demonstrable are in the stapes, annular ligament, and those parts of the labyrinthine capsule which are in the vicinity of the fossula ovalis. It appears that the superior and anterior circumference of the oval window is to be regarded as the seat of election of these changes.

The change which takes place in the capsule is a process of resorption of old, and apposition of new, metamorphosed tissue. Macroscopical examination reveals the stapes fixed to the oval window by bone, either along the margin of the footplate, or by means of bony trabeculæ from the stapedial crura to the walls of the fossula ovalis. In some cases the whole margin of the footplate is so fixed by bone that no trace of a joint remains. In many cases the fossula ovalis becomes more or less filled with spongy osteophytic outgrowths. Occasionally osteophytes encroach upon the interior of the labyrinth, and sometimes affect the fenestra rotunda also.

Coincident with these changes in the region of the stapes there may appear foci of osteoporosis in other parts of the capsule, notably in the region of the cochlea, in the modiolus and semi-circular canals. These foci spread towards the endosteum of the capsule, so that the intra-labyrinthine fluid may be separated from the large lymph spaces of the newly-formed spongioid areas only by a delicate membranous partition.

The exact process of this formation of the normal compact labyrinthine capsule into abnormal osteoid new growth has been carefully investigated by Siebenmann and Habermann. The necessary limit of time will not allow me to take you through all its stages in a lecture like this. Suffice it to say that the process begins in the Haversian canals, which become widened towards the side of the labyrinth by lacunar resorption of their walls. At some points this resorptive process proceeds further, whilst at others it results in the apposition of new bone.

Another and important point is that the capsule is peculiarly rich in remnants of primary cartilage, and these become disintegrated and replaced by new bony growth, as do also the cartilaginous coverings of the fenestra ovalis and stapedial footplate.

In the early stages of the condition there is a very sharp distinction between the newly-formed spongioid bone and the surrounding dense normal bone; this is in marked contrast to the absence of any line of demarcation between the spongioid tissue and the sclerosed bone formed in the later stages.

Nearly every investigator has endeavoured to find a cause for the condition I have briefly described. I will not detain you with all the pathengenetic theories that have been enunciated, but will give you the most important only. Numerous earlier theorists have ascribed to otosclerosis an inflammatory origin, but the rarity of any evidence of past or present tympanic inflammation, and the complete absence of signs of inflammation of bone, are strongly against this view.

One of the most probable explanations yet suggested is that of Siebenmann, who considers it to be the final stage of a developmental process which does not normally take place in the petrous bone, but which is the rule in other bones. As I have pointed out, the bony capsule of the labyrinth is rich in remnants of primary cartilage; these are found most frequently about the region of the fossula ovalis, which is the seat of election of the changes just described. In the long and flat bones growth, without change of shape, is brought about by a process of resorption and apposition after birth. The labyrinthine capsule, however, attains its ultimate size at birth, and the cartilage remnants it contains are not, therefore, used up; so that, unless the abnormal development which Siebenmann considers as constituting otosclerosis takes place, they are retained in the capsule until old age.

Gray rejects this theory as in no way explaining the involvement of the stapedio-vestibular articular cartilage. He points out that otosclerosis is rare before puberty, almost uniformly bilateral, more common in women, hereditary, and that certain bodily conditions are recognised as favouring its development (such as anæmia, pregnancy, gout, etc.). Reviewing these facts, together with the peculiar features of its morbid anatomy and the absence of any signs of inflammation, Gray suggests that the sharp line of demarcation between the areas of absorption and the healthy bone means death of the tissue in that area, and that the dead tissue is absorbed without the occurrence of infection. This view is the most satisfactory one at present advanced, and it is pleasing to know that it has been enunciated by a British otologist.

Having thus briefly reviewed the nature of otosclerosis, I must now pass on to certain points in its etiology before dealing with symptoms and treatment.

Otosclerosis is essentially a disease of young people. It rarely commences before the twentieth year, although its occurrence before that period is not unknown. It is far more frequent in women than in men, and the statistics of various observers range from 61 to 50 per cent.; taking my own cases, I find that women are in a majority of 5 to 1. Some explanation for this great preponderance of women lies in the relative frequency of anæmia and chlorosis in that sex, and to the anomalies of nutrition peculiar to the puerperium. It is not uncommon for otosclerosis to date from the occurrence of pregnancy.

A prominent feature in the condition is its hereditary nature. Denker, out of 306 instances, obtained a history of heredity in 40.5 per cent. So far as can be gathered, transmission would appear to have a tendency to take place through the female branches, and it is a known fact that harmful embryonal influences are more likely to affect the female than the male. This fact of heredity, which can hardly be doubted, supports Siebenmann's contention that otosclerosis is an abnormal post-embryonal development rather than a true disease, for, according to the laws of biological heredity, it is supposed that diseases cannot be inherited.

(a) A Post-Graduate Lecture delivered at the Royal Ear Hospital.

A number of agents have been suggested as *exciting causes* of otosclerosis, chief among them being gout, rheumatism, syphilis, anæmia, pregnancy, and the puerperal state, and severe chill. I need do no more than mention most of these, but syphilis and pregnancy require more than a passing notice. Habermann and Gradenigo have been the strongest advocates of syphilis, both congenital and acquired, as an essential agent in otosclerosis, but, so far as I know, there is no real supporting evidence. The aural manifestations of syphilis are definite and well-known, whereas in otosclerosis one sees no other evidences of the disease, nor is specific treatment of any avail.

Pregnancy and parturition are not infrequently assigned by patients as a definite cause of otosclerosis, and the puerperal condition almost always results in a decided increase in the deafness. This adverse influence is probably due to the blood condition, which may favour stagnation in the capillaries, and so bring about the local bone death suggested by Gray as the starting-point of the malady. The same remark applies to gout, rheumatism and anæmia.

Coming now to *symptomatology*, the chief manifestations of otosclerosis may be enumerated as deafness, tinnitus, vertigo and paracusis Willisii (or hearing better in a noise), together with several subsidiary symptoms.

The characteristics of the *deafness* are its markedly insidious onset and progressive nature. It is always bilateral, although one ear may be affected long before the other, even years. In the majority of cases the hearing is affected very gradually, so that patients can make no definite statement as to when the trouble first began. Sudden onset, although it may occur, is distinctly rare. The progress of the deafness is usually slow, and the condition may remain stationary for a variable, sometimes a long period. Again, a more or less rapid and marked accentuation may occur, the patient never recovering the ground thus lost.

Although I shall again refer to the deafness when I speak of the results of functional testing, I may mention here that, in pure ankylosis of the stapes, even in the later stages, the whisper can still be heard in the majority of cases, if only close to the ear, and spoken speech can always be heard. Where the perception of loud speech is lost, pure stapes ankylosis is no longer present, but there is superadded some advanced change in the structural characters of the labyrinthine capsule, or in the terminal nerve apparatus, or the fenestra rotunda is also involved.

Subjective *tinnitus* is a frequent symptom in otosclerosis, and often precedes the deafness. In character it may be buzzing, hissing, singing, humming, roaring, rattling, or pulsating. Though usually constant, it may, in some cases, be intermittent, and is occasionally so intense as to drive the patient to desperation. In one case of Denker's it led to suicide. It is often found that, when tinnitus is only occasionally present in the early stages of otosclerosis, it becomes constant later, and it does not invariably disappear when the patient becomes completely deaf.

Vertigo is not very common, and, when present, is usually slight in character.

The peculiar symptom of hearing better in a noise, or *paracusis Willisii*, is a remarkably constant and early symptom in otosclerosis. I need not enter into the various theories which have been advanced to explain this symptom, but I would impress upon you how frequently and early it occurs in otosclerosis; in one lady under my care it was noted within six months of the onset of the deafness. By most otologists it is considered to be a most unfavourable symptom, although Burkner believes that it is never present in cases which are complicated with affection of the sound perceiving apparatus, and therefore gives a comparatively favourable outlook.

Pain, slight and deep in the ear, and a feeling of tension in the ear, are sometimes complained of. Increase of deafness on straining to listen, due to the inability of the intra-tympanic muscles—put into vigorous action by listening—to put the fixed ossicles in motion, is not infrequent.

On examination the tympanic membrane is usually normal, or nearly so. The chief peculiarity to be noted is a reddish reflex over the promontory or in the area of the stapes This is, however, by no means present in every case. It is due to hyperæmia of the mucous membrane over the promontory or about the fossula ovalis shining through the membrane. This reflex, when over the promontory, is an unfavourable sign, as it points to the extension of the bony pathological process to the labyrinthine capsule.

The Eustachian tubes are patent, inflation giving a large, full sound, and being unaccompanied by improvement in either hearing or tinnitus.

It must, however, be remembered that otosclerosis may be complicated with chronic middle ear catarrh, which may alter the normal condition of the tympanic membrane, middle ear, and Eustachian tube.

In uncomplicated otosclerosis the upper air passages do not usually present any condition especially noteworthy.

Functional testing reveals the presence of what is known as "Bezold's triad of symptoms," viz.:—(1) increase of bone conduction; (2) a markedly negative Rinné; and (3) loss of low tones.

Increased bone conduction is found in uncomplicated stapes fixation, but when, later, the bony labyrinthine wall is the seat of foci of spongioid bone, the bone conduction becomes diminished. All cases presenting Bezold's triad of symptoms in association with normal, or nearly normal, tympanic membranes, and patent Eustachian tubes that have been subjected to post-mortem examination, have been found to have stapes ankylosis. When, however, the disease has so progressed that the changes in the stapedio-vestibular symphysis no longer preponderate, and foci of spongioid change have become marked in the cochlear capsule, the two conditions are opposed. The stapes fixation increases the bone conduction and renders the Rinné reaction markedly negative, whilst the marked spongioid processes in the labyrinthine wall diminsh the bone conduction and decrease the negative Rinné. Owing, however, to the fact that the region of the stapedio-vestibular symphysis is the seat of election of the condition, stapes fixation usually predominates. In rare cases—*i.e.*, in very early stages of otosclerosis—the result of functional testing will be normal bone conduction, reduced air conduction and positive Rinné. In such cases the acoumeter is diminished in proportion to the loss of air conduction, spoken speech is heard relatively well, and the whisper is reduced.

As the disease progresses, bone conduction may be found normal, air conduction absent, and Rinné negative, such cases standing midway between the increased and diminished bone conduction stages of the condition. The greater proportion, however, yield the result—bone conduction increased, air conduction reduced, and Rinné negative. Here the greater the increase of bone conduction the greater proportionately will be the loss of air conduction; acoumeter and voice will be diminished, whisper almost lost, and the lower tone limit will be reduced by one or more octaves.

When the spongioid changes have progressed to a stage when diminution of bone conduction preponderates, both that and air conduction will be found reduced, associated with a Rinné negative. Material reduction of bone conduction may need a differential diagnosis to be made from nerve deafness. This can be done by considering the loss of the lower tone limit, the comparative retention of high tones (as ascertained by the Edelmann Gatton-pfeife), the increasing duration of air conduction as the number of vibrations increases, and Gelle's test.

The last-named test is, I think, certainly useful, in spite of the adverse criticisms to which it has been subjected. Its chief objection lies in its difficulty of application. As a control test to Rinné's reaction, it possesses most value. Without further discussion, I may formulate the following results and their significance:—

(1) If Rinné is negative high up in the scale (to C), Gelle is also negative, and deafness is due to stapes fixation.

(2) If Rinné is negative below or up to C, and positive for higher octaves (C_2), the result of Gelle's test

indicates whether stapes fixation is to be assumed or not.

I have dwelt upon the results of functional testing somewhat at length because I believe them to be important, not merely from the diagnostic point of view, but as indications for treatment. The small attention that has been paid to tuning-fork tests by the majority of British aurists is the chief blot upon British otology.

The *course* of the majority of cases of otosclerosis is slow, but occasionally one meets with instances in which a quickly progressive diminution in hearing, with increasing tinnitus, leads to almost complete deafness within a few months. In the ordinary slow progress, exacerbations may occur, due usually to pregnancy, excessive body chill, anxiety and the like.

From what I have said you will gather that *prognosis* is the reverse of favourable. We are at present quite unable to cure the condition. In a few cases relief from the tinnitus can be afforded, or the otosclerosis even brought to a standstill. Those cases in which the reddish promontorial reflex, already alluded to, is present usually progress rapidly and ultimately reach a high degree of deafness.

Treatment does not promise much. I am not going to discuss the numerous operations—radical mastoid, removal of the stapes, or formation of a new opening in the bony labyrinthine wall—that have been suggested and practised with varying results, mostly the reverse of encouraging.

Prophylaxis, in regard to the evil effects of pregnancy and chill, should certainly be kept well in mind. Conception in otosclerotic patients should be avoided, and female descendants of otosclerotic persons should be advised not to marry.

When otosclerosis is present, numerous drugs have been suggested for its treatment. Iodide of potassium, in daily doses of about 15 gr. in half a pint of water immediately after food; antipyrin and salicylic acid in small doses; arsenic, iron, bromides, strychnine, thyroid extract—all have been recommended and found wanting. The drug which has received most universal attention is phosphorus, which, according to Mirwa and Stötzner, retards the formation of normal spongioid bone in the long hollow bones. It may be given in oily solution or in glutoid or keratin capsules, and is best administered in small doses given for a long period of time. Caution is necessary, as it may cause digestive disturbances.

As regards local measures, nearly all those hitherto employed have been with the object of mobilising the stapes. They resolve themselves into two groups—intra-tympanic injections and passive movements. Inflation with air alone (by catheter or Politzer douche) is useless, and may do positive harm. In place of air, steam, nascent chloride of ammonium, vaseline, pilocarpine, and solutions of pepsin have been suggested. More recently the use of a fluid ointment containing red oxide of mercury injected through the catheter and combined with rapid otomassage has been advocated.

The best results hitherto recorded seem to have accrued from the judicious application of otomassage, and I am inclined to believe that any successful treatment of otosclerosis will be obtained by this means.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Dr. Chantemesse, Professeur Agrégé of the Faculty of Medicine of Paris. Subject: "The Serum Treatment of Typhoid Fever (Antityphoid Opsonisation)"*

ON December 4th, Elisa Dehring, 50, a cook, lately in service at Crediton Road, West Hampstead, was before Mr. Paul Taylor charged with being accessory to the murder of a married woman, 28 years of age, who died in St. Mary's Hospital on August 9th last, as the result of an illegal operation. Mr. Symmons prosecuted for the Treasury. Mr. Paul Taylor committed the prisoner for trial at the Central Criminal Court, not, however, on the original charge, but, at the request of Mr. Symmons, for various other alleged offences in connection with the woman's death.

ORIGINAL PAPERS.

THE COLOUR OF THE MUCOUS MEMBRANES AS A GUIDE TO THE CONDITION OF THE BLOOD, AND AN INDEX OF THE NUTRITION OF THE BODY.

BY ALEXANDER HAIG, M.A., D.M., OXON., F.R.C.P., LOND.,

Physician to the Metropolitan Hospital and to the Royal Waterloo Hospital for Diseases of Children and Women.

SOME years ago I produced a card of graduated colours corresponding with those of the mucous membranes, the palest colour being that usually met with in chlorosis or anæmia, and the darkest being that met with in those who maintain a good standard of health and nutrition on a uric-acid-free diet (*a*). The other colours are intermediate between these extremes, and to make the card more useful I placed under each colour the numerical index of the corresponding blood decimal—*i.e.*, the decimal per cent. hæmoglobin divided by per cent. red cells. Now in chlorosis the common decimal is about .5 or less, and that of the deepest colour is more than a whole number—*i.e.*, 1.1.

We thus get four colours for comparison with the mucous membranes, and the numbers corresponding are .5, .7, .9, and 1.1, and in examining a case we can enter it in our notes as any one of these, or, if it is intermediate, then as .6, .8, or 1.0 (*b*).

I propose now to mention some of my results with this card, to describe the best methods of using it, and the extent to which it may be relied upon as an index of blood condition and general nutrition.

It does not, of course, pretend to be more than an approximate guide to the actual blood decimals, and whenever the pale colours indicate distinct diseased conditions, examinations of the blood itself should always be made to supplement the information given by the card, and also for the purpose of examining the numbers of the various kinds of cells and their forms.

The whole object of the card is not to do away with the necessity for blood examination, but to tell us, as it does in two minutes, whether there is, on the one hand, anything far wrong with the vital fluid calling for further investigation, or, on the other, whether a patient, whose blood decimal had been recorded six or twelve months before, was keeping up a condition of good and satisfactory nutrition, or whether that nutrition was improving or falling off.

The mucous membranes that are generally made use of for the purpose of obtaining the approximate blood decimal are those of the mouth and eyes.

It is well to have the patient seated on a chair, and facing a good light, but not in direct sunlight, which is apt to cause dazzling reflections. I may say that the cards are not intended for use by artificial light, and that if they are so used they will probably give results that are from 10 to 15 per cent. too high.

A fairly good idea of the index may be obtained simply by watching the patient smile; the only objection is that as the lips are drawn up, there is apt to be some pressure on the gums, squeezing the blood out of them so that the index may be too low.

The best way to examine the gums is to take the lower lip and pull it gently down so as to expose the lower gums without exerting any pressure upon them.

Having done this, place the colour card just below them and slide it along to right or left till the nearest tint to that of the gums is vertically below them.

It must not be expected that the colours will tone absolutely in all cases. It is practically impossible to produce artificially the exact tint of the blood as seen in the mucous membranes, but you should obtain as nearly as possible the tint or depth of colour visible in the gums, and if it is intermediate between two colours, mark it with an intermediate number.

In order that the result obtainable from the gums

(*a*) Copies of this card can be obtained from Messrs. Bale and Danielsson, London. Price 1s.

(*b*) Note the numbers on the cards at present obtainable have, for reasons which I explain in a forthcoming new edition of "Uric Acid," been marked too low and should be altered as above for comparison with ordinary standards of blood examination.

may be moderately reliable, there must be no irritation of any part of the gums from dental periostitis or the accumulation of tartar. Therefore, look at the general tint of the whole gum surface, not at one spot.

But since the colour of the gums may be misleading from some of these causes, it is always well to use other mucous surfaces for comparison, and to enter the result of such comparison rather than the colour of any one.

The colour of the lips, as seen in their natural position, is always too dark from the presence of pigment, but the tint of the inner surface of the everted lip may be used if this eversion can be managed without squeezing the blood out of it.

Again, if the tongue is clean, and it is protruded in such a manner as to force the blood moderately into the surface of its mucous membrane, this may give a fairly reliable index.

As to the eye, the blood decimal may be read from the lower lid simply by pulling it downwards (though this is very often congested, and yields too dark a colour), or, better, while gently fixing the lower lid, make the patient look outwards, so as to expose the mucous membrane covering the caruncle at the inner canthus, and take the general tint of the surface thus exposed.

In all cases it is the general tint or the average tint of all these exposed mucous surfaces, rather than the tint of any one of them, that is to be used in arriving at the approximate blood decimal.

Now as to the use of this blood decimal when obtained. It has long been my habit to note this in all patients when they first come to me, and at each subsequent visit, and the observation is so easily and quickly made that it soon becomes a routine.

I thus get most valuable information as to the condition of the blood and general nutrition, and am able to see at a glance whether a patient is improving, standing still, or going back, as time goes on.

As a rule, middle-aged people living on an ordinary mixed diet do not show a blood decimal above .7, or at most .8, and, of course, those who come to a doctor are not in the best of health, or they would not come.

But those who live on a mixed diet never have quite such a high blood decimal as those who live on the uric-acid-free diet, and while 1.0 and 1.1 are reached by those who do well on this diet, and have been on it for about three or four years, and especially by children and young people whose nutritive processes are active, there are practically no meat-eaters who attain to 1.0, just as there are no meat-eaters who have as quick a capillary circulation as those who swallow no unnecessary uric acid.

Those who attempt to get on to the uric-acid-free diet, but fail from one cause or another to take sufficient albumen, not only do not show an improving blood decimal, but often present to us a great and decided falling-off below even the level of the ordinary meat-eater, because to alter diet without taking sufficient nourishment is to have low acidity of urine and high alkalinity of blood; hence the blood is flooded with uric acid from the old stores, and the blood decimal rapidly deteriorates.

Such people have depression one day and rheumatism the next, as the uric acid excess oscillates back and forward from the blood to the fibrous tissues, and from the fibrous tissues to the blood, and it is the latter change that markedly brings down the blood decimal.

This is well seen in the case of chlorosis, especially if the chlorosis (as is often the case) has been preceded by rheumatism.

It is the very same uric acid which in the girl of 13 causes rheumatism, and in the same person at 17 causes chlorosis, and between these two ages there is a more or less constant alternation of excess of uric acid in the blood, with increasing anæmia, and excess of uric acid in the joints and fibrous tissues, with increasing rheumatism.

And the blood decimal will at once tell us which way the pendulum swings, for with rheumatism at 13 there is a much higher decimal (at first almost normal—say, .9 to 1.0), and with chlorosis at 17 there is a much lower decimal tending to get even lower still if the case is untreated.

When I see a case of chlorosis with a decimal of .5 or less, I never put that on to a uric-acid-free diet, as to do so would aid the solution of uric acid in the blood and make matters worse.

Here we must first cure the patient with iron and any food she can best take to make sure of sufficient albumen (without which neither good blood nor any other tissue can be made), and when the decimal has got to .7 or .9, then slowly alter the diet, taking great care that the proper quantity of albumen is not on any account allowed to be missed.

For similar reasons the gouty old squire type of patient (who leads a healthy out-door life and is troubled by nothing except occasional gout in his big toe) is the one who shows, as a rule, the best decimal for the meat-eaters, and may even get up to .9. For he, like the rheumatic girl of 13, is exactly the person who has most uric acid in his joints and fibrous tissues, and least in his blood.

And this is a favourable condition for the blood, which shows a relatively high decimal.

But when this man breaks down from advancing years, or breaks his leg in a motor smash, or is otherwise laid up, there comes his bad time, and all the uric acid stored in his tissues in previous years begins to pass into his blood, and his decimal falls to .7, .6, or even lower, according to the amount of uric acid passing through the circulation, and the length of time it continues to be present in the blood in excess.

The blood decimal of the ordinary mixed feeder is about .6 or .7, and if he alters his diet you must be content if it does not fall off in the first six or nine months.

By the end of twelve months it may have begun to improve slightly; in the second twelve months there should be more decided improvement, and by thirty or thirty-six months it should be .9 or 1.0 if nutrition is being properly kept up (*i.e.*, if sufficient albumen is being taken).

And this is where the great value of the colour card shows itself. It would be absurd to examine a patient's blood at every visit. If it has been examined at the first visit and found normal except for deficiency of colour, and if colour has been improving on the reformed diet, it is unnecessary to examine the blood at each visit, and there are few patients who would care for the trouble involved.

But with the card one can feel confident that one is not overlooking any serious blood disease, and if the decimal is improving one knows with practical certainty that nutrition is satisfactory.

Again, the card is of great use in the treatment of anæmia and chlorosis by iron or other drugs (*e.g.*, iodide of mercury often more powerful than iron—see case and fig. in "Uric Acid," Ed. VI.) which clear the blood of uric acid; and it is because iron clears the blood of uric acid it does good in chlorosis and anæmia. If such troubles as dyspepsia or diarrhœa prevent it acting on the uric acid and clearing it out of the blood, then the blood decimal will not be found to improve under its administration.

But under ordinary conditions the decimal improves so much under the proper administration of one of these drugs that if the card is used, say, once a week, a quite visible improvement can generally be observed and recorded. The improvement (except under iodide of mercury) is often slow at first, but becomes more marked in the third, fourth, and subsequent weeks.

For all these purposes the card is most useful, but it is a good thing to examine the blood also at the first visit, as this ensures that nothing is being overlooked, and also gives us an opportunity of comparing the result with the reading given by the card.

On the other hand, if the colour does not stand still on the new diet, but falls lower and lower, we may infer either that the patient is not doing the diet correctly (*i.e.*, has not left off all the poisons), or that he is not taking sufficient albumen.

For the blood will not improve if nourishment is deficient (nothing can be made out of nothing), and this is so even if drugs are being used. The blood decimal will not improve on iron if nourishment is deficient, or if dyspepsia prevents its full and complete utilisation. Dyspepsia may also hinder recovery by preventing the absorption of the iron.

If we follow these facts carefully it soon becomes evident that the cause of anæmia is the presence of excess of uric acid in the blood; and that its cure by drugs (iron, mercury, copper, etc., all of which form insoluble compounds with uric acid) is the clearing of such excess out of the blood, though the cure is often temporary enough, as the urate is only driven into the fibrous tissues (where it may cause various amounts of pain as evidence of its whereabouts), from which it is practically certain to return into the blood at some future time when the retentive effect of the metals has passed off; and that its prevention is the keeping of the body moderately free from any large quantities by means of the uric-acid-free diet.

All this and much more, which I have no time to mention, is rendered sufficiently obvious by the steady routine use of the blood decimal card.

A little practice soon gives all reasonable accuracy as to the results recorded, and the card is a boon to the busy practitioner, who can carry in his waistcoat pocket a means of testing in a moment the blood condition of numbers of patients, when lack of time would quite prevent him from drawing a sample of blood and estimating both cells and hæmoglobin with instruments. But he can always fall back on his instruments when the colour card reveals the presence of very abnormal conditions.

I say again the card gives only the approximate blood decimal, but its constant use reveals many interesting facts as to the causation and concomitants of anæmia and chlorosis, and their relation to uric acid and rheumatism, and the effects of treatment by drugs or diet in prevention or cure.

DIPHTHERIA AND SCHOOLS. (a)

By JAMES NIVEN, M.A., M.B.,

Medical Officer of Health, Manchester.

THE subject may conveniently be divided into two parts, the first concerning itself with the question whether elementary schools have caused an increase in the prevalence of diphtheria and the manner in which it spreads in schools; the second, with the mode in which the spread of diphtheria in schools may be combated, and the relation of such action to the prevention of diphtheria generally.

It does not follow because diphtheria spreads in elementary schools that the incidence of the disease must be increased by increased attendance at school. This problem has for a long series of years been studied by Sir Shirley Murphy, in a manner calculated to give an answer to the question raised. From a comparison of the death-rate from diphtheria and membranous croup at school ages, and at younger as well as more advanced ages, in the decade preceding the Elementary Education Act, 1870, which made attendance at school compulsory, with the death-rate from these conditions at the same age groups in the decades following and in the quinquennial period 1901-05, he shows that the diminution of the death-rate at school ages has been less than that occurring at other ages, or the increase has been greater at that period of life.

The incidence of diphtheria has, in fact, been shifted so as to fall more than formerly on children at school ages. Nor can this conclusion be said to be invalidated by the greater precision which has been attained in respect of diagnosis in recent periods, as Sir Shirley shows.

Granted, however, that so much has been clearly made out, it does not necessarily follow that a greater total incidence of diphtheria has thereby been produced, since, unless it can be shown that school life has a special tendency to produce outbursts of diphtheria such as would not occur in the ordinary course of life of children not attending school, all that has occurred may have been merely a shifting of incidence and not an increase of the total number of cases. It might be supposed, for example, that, if school children remained at home, and were infected, as a number of them no doubt would be, the younger ones being more in contact with those still younger than themselves would infect them to a greater extent than before, and the older ones being, perhaps, at work would increase the amount of diphtheria amongst their seniors. Nor are there wanting occasions on which the closure of schools has seemed to produce such a result.

Sir Shirley Murphy has been led to consider the effect of school holidays on the incidence of diphtheria, and he has shown that the autumn holiday produces a decided diminution in the reported number of cases, both of diphtheria and of scarlet fever, amongst children at school ages, a diminution which is not necessarily experienced either at younger ages or amongst older persons. Here, again, there can be no doubt that the effect of school attendance in summer is arrested by the advent of holidays, but it is not certain that the improvement at school ages is entirely real, or that, even if it were, the effect of the holidays at that season is not a more important factor than the interruption of school life.

It will be seen that, even after Sir Shirley's refined and elaborate analysis, the question of the effect of school life on the spread of diphtheria in the community admits of further study. I have, therefore, referred first to the careful investigations made by the staff of the Local Government Board into particular outbreaks of diphtheria, in the period preceding the discovery of the diphtheria bacillus, and in the subsequent period before it had come to be considered a necessary part both of investigation and administration, as well as to Sir Richard Thorne's work, which summarises these and other reports.

From these sources we learn that the manner in which outbreaks of diphtheria are preceded and accompanied by slight sore throats, plainly of a diphtheritic nature, was clearly made out. The part played by other infectious diseases, and particularly by scarlet fever, in causing diphtheria was emphasised. The infective power of special cases, and the persistence of infective power in particular cases, were recognised. The effect of rhinitis in causing infection was not, and could not be, so clearly defined, as it has subsequently become. But the influence of the school was in some instances sharply defined, and it was shown by Mr. Power, in one outbreak, that the children at school were living in an infected atmosphere, similar to that existing in households invaded by diphtheria. Mr. Power also emphasised the manner in which diphtheria introduced, on more than one occasion, into the village school, by cases with slight or without clinical symptoms, appeared to gather intensity as one child after another was attacked. On another occasion, school children apparently became affected in the course of scrambling play along with other infected children, but in a manner independently of school life. On a third occasion where a day-school was severely invaded, the disease spread especially amongst the children living in a particular part of the district.

It appears evident that the aggregation of children in elementary schools must have the effect of diffusing diphtheria in a number of instances sufficient when taken together to affect the total incidence of the disease, and that the power of the schools to affect the total incidence of diphtheria will be greatest in sparsely-populated rural districts.

It has appeared to me that it would be advantageous to study more closely the behaviour of diphtheria in relation to schools in the city of Manchester, a study for which I possess a number of apposite facts.

Premising that the cases may, with few exceptions, be regarded as diphtheria, owing to the careful bacteriological and clinical sifting to which they have been subjected, I give the facts as follows.

As regards the number of cases accepted finally as diphtheria in individual years from 1897 to 1906, and the aggregate numbers accepted, at each year of life up to ten, in the aggregate a great increase is shown in the number of cases at age three, which is the year of maximum incidence. A small decline takes place at ages four and five, and a marked drop at age six. Now, in Manchester, the numbers attending school at age three are not much over one-third of the numbers attending at age four, and the numbers attending at age four do not greatly exceed one-half of the numbers attending at age five.

(a) **Abstract of Paper read before the Second International Congress on School Hygiene, London, 1907.**

Hence the year of maximum incidence precedes the years of school life. It is, however, the year in which children will first be brought into intimate intercourse with each other and with school children in the course of play out-of-doors. I have already mentioned one instance in which the scramble of play appeared to have a special influence in the diffusion of diphtheria.

A study of the facts for individual years appears to show that as the wave of diphtheria rises the number of cases increases most markedly at school ages and at younger ages, the increase in adults following later. Further, as the wave rises year by year there is a tendency for the age of maximum incidence to advance to the fourth year, and in exceptional cases to the fifth. In every year there is a marked drop in the number of cases in the sixth year of life. The influence of school is thus a special one, and is most marked when the total incidence of diphtheria is greatest—that is to say, when more opportunities are given for its manifestation. This is a result which Sir Shirley Murphy had also arrived at by his method of examining the subject. The great drop at age six is probably due to the widespread establishment of immunity.

Next, there is the number of cases for ten years of diphtheria occurring in the separate elementary schools of Manchester, quarter by quarter. That the significance of this statement may be understood, it is necessary to premise that the number of public elementary schools in 1906 was 177, and the number of children on the books 109,765, the average attendance being about 90 per cent. It will be seen that diphtheria affects particular schools in two forms, either as special outbursts or in the form of a low and steady persistence.

The latter form is greatly influenced by the number of scholars and by the amount of the disease present in the district. The outbreaks or flare-ups, however, which take place in particular schools are more or less independent of these circumstances and constitute the true school influence. They are due, no doubt, to the aggregation of susceptible children in the infant departments of the schools affected, subjected to some particular cause of a temporary character.

It is probable that this cause is the presence of some child or children possessing the power to produce copious discharges, rich in diphtheria bacilli, while themselves not suffering. Many such cases have been found, particularly among cases of diphtheritic rhinitis, whether post scarlatina or otherwise, but the tonsils also are affected in a similar manner.

The tendency of such flare-ups to last only a limited period, and to burn themselves out, provided no more children are meantime introduced into the class, is a noteworthy circumstance.

It cannot be doubted that such flare-ups, which are a special product of the aggregation of susceptible material, do add to the diffusion of diphtheria in the community. The degree to which they do so is to be measured by the number of such flare-ups and the number of cases occurring in course of them. Yet it is not to be forgotten that similar occurrences would, though less frequently, take place independently of elementary schools.

Another interesting mode of considering the question is the comparison of the death-rate from diphtheria in the three main divisions of Manchester at ages 0—3, 4—14, and above 15. It will be seen that while the death-rates at ages 0—3 and above 15 do not differ widely in the three divisions of the city, the death-rate in North Manchester is between two and three times as great, at school ages, as the corresponding death-rate for the Manchester township. This is the more remarkable inasmuch as the Manchester township is the poorest portion of the city, and, on the whole, possesses the poorest schools. It might be inferred that school diphtheria pursues a course of its own, independent of that followed by diphtheria at other ages. As we have seen, this is true only partially, and the figures require explanation. It is, however, partially true.

This comparison leads us to observe that the sanitary condition of the schools appears to have, upon the whole, little to do with the occurrence of these outbreaks, which are, in a measure, fortuitous, and dependent apparently on the aggregation of children not yet immunised, and on their opportunities for infecting each other. It has been suggested to me by my assistant, Dr. Goldsmith, that the absence of playgrounds in the centre of the city may be the essential fact, a suggestion which chimes in with the conclusion to which I had already come that the scramble of play was probably the most important fact in the diffusion of diphtheria. Nevertheless, crowding together in the schoolroom and the use of common articles must also contribute.

I have also analysed the cases of diphtheria occurring in a particular year—an analysis which, while establishing some degree of exchange of infection between school and younger children, again appears to show that diphtheria in school children is largely spread in school, and diphtheria in persons outside school is largely spread independent of school.

It is, however, very difficult to arrive at a secure position. It is manifest that diphtheria is one of those diseases in which the slight or latent cases far outnumber the discoverable cases. This is probably true also of enteric fever, pneumonia, and cerebro-spinal fever.

All these different lines of investigation, then, go to show that diphtheria finds in the earlier period of school life a favourable occasion to extend itself, and that, in fact, it is in this manner widely diffused.

Some facts given by Dr. Graham Smith in his excellent paper in the *Journal of Hygiene*, Vol. II., go to show that about one-half of school children and a much higher proportion of adults may have harboured diphtheria on a membrane sufficiently invaded to have allowed the system to absorb toxin in small quantities, and so to elaborate a protective anti-toxin. Moreover, when diphtheria has definitely invaded a school, the proportion of harbourers is always high.

Further, Dr. Graham Smith shows that the proportion of persons in the poorer districts of an urban community harbouring the Hofmann bacillus is generally high, and I would suggest that in this circumstance may be found the explanation of the comparatively low incidence of diphtheria on the poorer districts. It is not suggested that there is not a pseudo-diphtheritic bacillus, but that the "short" or "suspicious" bacillus is frequently a true diphtheria bacillus, and in all probability the so-called Hofmann bacillus has frequently been a diphtheria bacillus. I understand from Professor Delepine that he recognises the short form of the diphtheria bacillus by its rapidity of growth on Loeffler's serum, by its cultural characters, by the arrangement of the bacilli in cultures, and by the development of involution forms. There appears to be a considerable margin of doubtful forms, which may be capable of slowly producing immunity. No doubt Professor Cobbett's work is valuable, in giving more precision to the observation of morphological differences. At the same time, the facts seem to point to a widespread production of immunity, especially in the poorest districts, through bacilli of comparatively low virulence. It would be highly interesting to know whether a similar difference exists in different parts of other large towns.

How, now, are we to deal with the occurrence of diphtheria in school? It appears impossible, usefully, to separate this question from the allied one, how we are to deal with diphtheria generally. It is now admitted that all cases of suspected diphtheria should be examined bacteriologically, and it may be added that swabs should be taken from both throat and nose. It is further generally admitted that, while bacteriological confirmation should be sought in all cases, medical practitioners should inject antitoxin on the appearance of suspicious signs and symptoms without delaying to ascertain the result of bacteriological examination. Nevertheless, swabs are not and cannot always be carefully taken, and the conditions are not always favourable to the taking of swabs which will yield true results.

Further, unless the public health bacteriological examinations are made by experts, with great experience, there is a decided risk of cases being classified as not diphtheria which should not be so classified. On both accounts, there is a real danger that the establishment of bacteriological examinations may lead to the spread of diphtheria, owing to a false sense of security being produced in respect of infective persons.

No serious case of throat illness, presenting signs of diphtheria, should be entirely rejected simply on bacteriological grounds, although the absence of diphtheria bacilli should cause caution to be exercised in placing such persons in the same ward with clear cases of diphtheria, for the sake of the latter.

The clinical diagnosis, then, still remains as necessary as ever, and bacteriological examination must be regarded as only an aid, especially in the absence of a staff such as the Public Health Authority in New York has provided.

In the circumstances of public health administration holding in this country, it is very desirable that all cases of diphtheria should be removed at the earliest possible moment after the commencement of symptoms. If this cannot be done, a serious responsibility rests on the medical practitioner who omits to administer antitoxin within the first three days of illness.

No further principles of action can be laid down applicable to all authorities, nor does it seem desirable that they should be. If, under any system of administration, there is very little diphtheria in the district, and schools are not invaded, it would be better to continue on existing lines, until a necessity arose for acting otherwise. *Quieta non movere.* If diphtheria is present in the district at a moderately high level, more action is called for. In that case, bearing in mind the necessity of submitting all specimens to a bacteriological expert with large experience, and versed in public health work, swabs should, when possible, be taken by an officer of the sanitary authority from the throat and nose of members of any family who have been exposed to infection, and should be submitted to bacteriological examination.

Cases harbouring diphtheria bacilli should receive a prophylactic dose of antitoxin, and may usefully be removed to an isolation hospital to be kept under observation until free from bacilli on three negative swabs. No child attending school from such a family should be allowed to return to school while harbouring bacilli. Breadwinners may be allowed more latitude. But even breadwinners should not go to work while harbouring bacilli, without being required to use precautions in the way of antiseptic gargles, and nasal douching of a gentle character with antiseptics.

Cases isolated in hospital are, usually, not discharged except after three negative swabs have been taken. But Dr. Newsholme's practice appears to be a good one—viz., to exclude diphtheria convalescents from school for six weeks after discharge from school and recovery at home. Apart from the question of infection, such children are often weak, and susceptible to other forms of disease—a consideration which might well be taken into account by school authorities in connection with other forms of disease. There are considerable difficulties in the way of obtaining three negative swabs from children treated at home, and on this account also Dr. Newsholme's plan appears a good one.

THE ACTION OF CERTAIN SALTS OF FORMIC ACID ON THE CIRCULATORY AND MUSCULAR SYSTEMS. (a)

By ALEXANDER GOODALL, M.D., F.R.C.P.ED., AND ISABEL MITCHELL, B.Sc.

DR. GOODALL first referred to the extensive use which was at present made of formic acid and its salts in therapeutics, and to the very laudatory terms in which they had been advocated, particularly by French writers. He thought that some of the assertions as to the scope of formic acid were extravagant, and noted that Dr. Ker and Dr. Croom, who had written a paper on the use of these remedies in diphtheria, were much more cautious in their statements than Huchard had been. He had thought it, therefore, important to investigate the physiological action of the formates by experiments on animals. In the work he has made use of ordinary physiological methods, and as he had found that formic acid was too irritating to admit of its use, he had employed the salt of sodium, potassium and calcium.

Effect on Blood-pressure.—In the case of all these salts the only action observed was a depressant one; that is, the drug, as soon as it produced any noticeable effect at all, was toxic. Sodium formate had little action of any kind, except in strong solution, and the fall in blood-pressure was usually temporary. Potassium formate was more powerfully depressant, and was fatal in strong solutions. Calcium formate was depressant in dilute solutions; in stronger solutions the blood-pressure was raised again. Formic acid was purely depressant. In the case of sodium, potassium, and calcium, the action of the metallic ion preponderated over that of the formate. The Na-ion was inert; the Ka-ion was depressant; and the Ca-ion raised the blood-pressure. The next series of observations were made on the vessels of the isolated heart, with much the same result; potassium formate was rapidly toxic; sodium formate transiently so, and calcium formate stimulating. Their actions on the vessels were also tested by counting the rate at which drops fell from a divided artery of a frog when the circulation was perfused with solution of formate. All the salts caused a transient vaso-constriction followed by a longer period of vaso-dilatation. Sodium formate caused least vaso-constriction and most vaso-dilatation; potassium formate caused most vaso-constriction and least vaso-dilatation, while calcium formate was intermediate between the two.

The action on skeletal muscle was investigated on ordinary muscle, never preparations. The general effect of the formates was greatly to lengthen the latent interval, and to induce fatigue more quickly. Some experiments on man were also undertaken. In doses of several grammes no subjective sensations whatever were experienced. Tracings were taken by means of the ergograph. Some of the observers practised with the ergograph until a uniform tracing was secured; others took simply a tracing before and after formates. It is well known that in using the ergograph great improvement is manifested in the errors after a little practice. In the case of the two subjects who practised formates seemed to diminish the output of work. In the observer who did not practise the ergograph, tracing after formates was slightly better than that taken before the drug was administered. Records made by the dynamometer showed no improvement after formates. Lantern slides of the various tracings made were shown, and fully confirmed the statements made by Dr. Goodall. The conclusions were that formates were almost useless drugs; in all probability they were rapidly converted into carbonates in the tissues. Sodium formate was practically inert. Calcium formate might find a sphere of usefulness as a readily absorbed and not unpleasant calcium salt, and be given in cases of hæmorrage, such as hæmophilia in which the action of the Ca-ion was desired.

LORD STRATHCONA presided over a special meeting at Saffron Walden, held in aid of the Essex Asylum for Idiots, Colchester. A resolution was unanimously passed that the meeting approved of a special effort being made in the district to raise £5,000 for the purpose of building an isolation hospital near the asylum for the treatment of tuberculosis and other infectious diseases.

(a) Abstract of Paper read before the Edinburgh Medico-Chirurgical Society, December 4th, 1907.

OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Pott's Fracture.

By Peyton Beale, F.R.C.S.

Amongst the out-patients was a man, æt. about 50, who was complaining of considerable œdema of the right foot, very marked trophic disturbances evidenced by eczema over the region of the lower end of the fibula, wasting of the muscles of the lower part of the leg and foot, with inability to bear weight on the latter. On feeling the fibula it was evident that he had suffered from a Pott's fracture, and from his history it appeared that this had occurred about 18 months ago. He said that his leg had been put up in splints, and he had been admitted to a hospital, where he remained for six or seven weeks. The leg and foot were then put up in plaster, and this was removed about six weeks subsequently. On examination there was a great amount of thickening about the lower three inches of the fibula, including the external malleolus; the patient had a flat foot, with very marked eversion of the foot; the skin over the lower end of the fibula was thin and eczematous, and there was a small ulcer commencing just above the malleolus. Mr. Beale said that this state of affairs was found very commonly after Pott's fracture in oldish people. There were, of course, many varieties of fractures of the lower end of the fibula. The fracture nearly always occurred at the weakest part of the bone at a point about three inches above the tip of the malleolus, the upper end of the lower fragment being displaced inwards; this resulted in an outward displacement or eversion of the foot. The different varieties of the lesion were mainly due to the injuries which took place at the inner malleolus as to whether this was fractured or whether the internal lateral ligament was ruptured to a greater or lesser extent. Accompanying fracture there was commonly considerable effusion of blood, and when the blood clotted and subsequently became organised, it caused blocking of lymphatics and veins, often leading to considerable œdema. He ventured to think the following line of treatment was the best to adopt in order to obtain the best results: for the first two days an evaporating lotion should be applied to the leg and foot, the patient lying in bed with the foot raised; then a Dupuytren's splint should be used. This is applied on the inner side of the leg, its upper end being fixed below the knee; a large pad is inserted between the splint and the leg about three inches above the internal malleolus; the foot is then securely bandaged to the forked lower end of the splint, so as to fix it in a position of marked inversion; the splint should be removed twice daily, and the foot and leg massaged from below upwards. If for any reason there is an objection to the Dupuytren's splint (by its use alone it may sometimes be difficult to counteract backward displacement of the foot), a back splint with a foot piece may be employed. The foot piece should be at right angles to the splint, but should be fixed "on the skew" in such a way that when the sole of the foot is applied to it, it keeps the foot in a position of marked inversion. Such a splint is found to give great comfort to the patient, and most effectually prevents the eversion and flat foot which are found so commonly to occur after Pott's fracture.

As regards this particular case, the only thing to be done now was to carefully strap the foot, inverting it as far as possible, and apply massage to the leg daily; the strapping should be renewed as the œdema diminished. Of course, proper dressings would be applied to the ulcer and eczematous skin before the strapping was put on. The patient would also be given a tonic containing iron, quinine and magn. sulph.

OPERATING THEATRES.

WEST LONDON HOSPITAL

Case Illustrating One of the Complications Following Iliac Colostomy.—Mr. Swinford Edwards operated on a woman, æt. 54, who had been admitted with advanced carcinoma in the upper rectum. A careful examination showed that the disease was fixed to the sacrum, and, as the stenosis was considerable, Mr. Edwards thought that a colostomy should be performed without delay. The patient was somewhat obese, and the abdominal wall was flaccid and pendulous. The operator made the ordinary incision, but on account of the adipose tissue it had to be of greater length than usual. After the various muscular layers of the abdominal wall had been split in the direction of their several fibres, the peritoneum was opened. The colon was easily found, and as the mesentery was sufficiently long, there was also no difficulty in bringing a knuckle well out through the wound. The parietal peritoneum was next sewn with interrupted sutures to the edge of the skin wound. A glass rod was now passed through the mesentery transversely across the wound, resting on the abdominal wall on each side of the incision. In this way the posterior wall of the bowel was on a higher level than the surface of the skin, thereby ensuring, as the operator pointed out, a good spur. The bowel was now fixed to the margin of the wound with several interrupted silk sutures, passing, where possible, through one of the longitudinal bands. Several appendices epiploicæ were ligatured and removed, the ligatures in a good many instances being used afterwards as sutures, thus anchoring the bowel yet further to the abdominal parietes. The bowel was not opened, and after a layer of protective matter had been placed over the operation area, the usual dressings, consisting of gauze and cotton wool, were applied, a many-tailed bandage being put on over all.

The subsequent history of the case was as follows: Mr. Edwards opened the bowel on the third day by slitting it up from end to end—that is to say, in the long axis of the gut. On removing the dressings, the glass rod was found loose in them, having slipped from under the gut. The bowels acted after a lapse of another two days, and all went well until ten days after the operation, when the patient, being troubled with a bad cough, felt something occur under the dressing, after a violent fit of coughing. Thinking that there was an action of the bowel, a nurse was called, and on exposing the wound found that a large knuckle of small intestine had prolapsed by the side of the artificial anus at the upper part of the wound. The house surgeon was communicated with, and, as Mr. Edwards's colleague, Mr. Bidwell, happened to be in the hospital, he was asked to see the case. It appears that the bowel had been prolapsed a sufficient time to allow a coating of lymph to form. The gut having been carefully cleansed, was returned, and four or five deep silkworm gut sutures were passed in through the upper part of the wound, including the walls of the colon, and, in order to afford greater support, they were passed through all its coats, thus effectually preventing any further prolapse. Four days after this second operation, it is satisfactory to record, the patient appeared none the worse for this accident. Mr. Edwards remarked that it is well-known the chief risk in colostomy is prolapse of the abdominal contents. He had never known, however, this accident to occur so late as in this case. In his opinion the following reasons conduced to the *contretemps*: (1) a large pendulous and flabby abdomen; (2) the employment of a glass rod instead of sutures; (3) the union of the parietal peritoneum to the skin; and lastly (4) the occurrence of undue muscular expulsive efforts due to the cough. In this case Mr. Edwards said he used a glass rod in order to get a better spur than even could be got with a deep suture. He sutured the peritoneum to the skin, a method which he largely practised in former days, but which he has since abandoned in the majority of cases. He did this on the present occasion in order to cut off the subcutaneous fat from the wound, hoping thereby to prevent fat necrosis and suppuration, which are of somewhat frequent occurrence after the operation of colostomy in the obese. In any future case where he judged that it was advisable to suture the peritoneum to the skin, he would substitute for the glass rod a deep mesenteric stitch, passing through the mesentery and both lips of the wound. Should this method not appear to sufficiently raise the colon, a glass rod might be used in addition. Practically, he remarked, he always used the deep suture, as by this method the large opening into the abdomen is converted into two small openings. This undoubtedly prevented any prolapse of the abdominal contents, even should no peritoneal sutures be placed into the gut.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE

NEUROLOGICAL SECTION.

MEETING HELD WEDNESDAY, DECEMBER 4TH.

The President, Dr. C. E. **BEEVOR**, in the Chair.

Dr. J. S. **COLLIER** read a paper on

CERTAIN PECULIARITIES OF INTRA-CRANIAL GUMMATA IN RELATION TO THE EFFECT OF ANTI-SYPHILITIC TREATMENT.

He first gave an account of the case of a middle-aged man who had developed additional symptoms (optic neuritis, hemianopia, etc.) actually during the time he was being energetically treated for a gumma. Recourse was then had to operation, and a small, very fibrous gumma was removed. Dr. Collier pointed out that gummata should be sharply divided into two classes—(1) rapidly growing diffuse growths presenting clinically two characteristic features—acute onset and general symptoms (headache, vomiting, and early optic neuritis). These cases respond well to anti-syphilitic remedies. Many of them are really cases of acute hydrocephalus due to syphilitic ependymitis. (2) Slowly growing tumours characterised clinically by the presence of facial symptoms (epilepsy, etc.), and by the late development of optic neuritis and other general symptoms. This late development of general symptoms was probably due to changes in the vicinity of the gumma. The present case belonged to this group. Many of these cases also responded well to medicinal treatment, but some did not. He emphasised the fact that the cases not responding to medicinal treatment usually belonged to the second group, and could be localised so that operative treatment was clearly indicated.

Sir VICTOR **HORSLEY** concurred in all Dr. Collier's remarks, and narrated a case throughout similar to the one described by Dr. Collier.

Dr. PURVES **STEWART** raised the question of the duration of medicinal measures, and stated that examination of the cerebro-spinal fluid for lymphocytosis was important, as sometimes this sign was present—indicating a syphilitic nervous affection—when no other symptoms revealed the presence of the lesion. Thus treatment should be continued not only until the symptoms disappeared, but also until the lymphocytosis subsided.

Dr. FARQUHAR **BUZZARD** agreed with Dr. Collier that some cases even of the second group recovered with medicinal treatment.

Drs. F. E. **BATTEN** and GORDON **HOLMES** read a paper on

THE NERVOUS SYSTEM OF A DOG SUFFERING FROM ATAXIA AND INVOLUNTARY MOVEMENTS.

The animal has had choreic movements, failing vision and smell, apathy and marked mental deterioration. At post-mortem was found: cell infiltration of the perivascular region, the cells being lymphocytes and plasma cells. The changes were strongly reminiscent of those found in general paralysis of the insane, except that the ganglion cells were but little altered.

Sir VICTOR **HORSLEY** pointed out the similarity of the changes to those found in rabies.

Dr. T. GRAINGER **STEWART** read a paper on

FOUR CASES OF TUMOUR OF THE FOURTH VENTRICLE.

These cases were very difficult to recognise, and one had chiefly to rely on the absence of signs indicating positive or cerebellar disease. He laid stress on the sudden onset of the symptoms, the fact that there was giddiness which increased on movement, and on the slow, coarse nystagmus, equally marked in both lateral directions; death was often sudden.

Dr. DAVID **FERRIER** discussed the symptomatology.

Dr. F. E. **BATTEN** referred to a case in a child with whom vomiting was the only symptom.

Dr. S. A. K. **WILSON** also referred to a case. It was characteristic of these lesions that the symptoms till near the end were only general.

Dr. FARQUHAR **BUZZARD** read a paper on

A CASE OF TUBERCLE OF THE SIXTH NUCLEUS ON ONE SIDE.

The patient, a woman æt. 42, had had signs of tumor cerebri, and then died of tuberculous meningitis. At the autopsy was found degeneration in the posterior longitudinal bundle on the opposite side to the lesion of the sixth nucleus. According to Bruce this bundle does not cross the middle line in its course, and this case might be adduced as indicating that it reached the opposite third nucleus by crossing immediately on leaving the sixth nucleus. It was not conclusive, however, for the degenerated fibres might have originated, not in the sixth nucleus, but in Deiter's nucleus.

Sir VICTOR **HORSLEY** was of opinion that the degenerated fibres certainly came from Deiter's nucleus, which in his opinion was to be regarded as the centre regulating conjugate movement, and not, as previously thought, the sixth nucleus.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, NOVEMBER 22ND, 1907.

The President, Dr. A. R. **PARSONS**, in the Chair.

VILLOUS TUMOUR OF THE BLADDER.

DR. **BOXWELL** stated that the patient from whom the specimen was taken was a young man, aged about 34, who had been perfectly healthy until about 12 months previous to his admission to hospital. The chief symptoms on admission were hæmaturia with pain on, and increased frequency in, micturition. The urine was found to be alkaline, full of pus, and in addition contained triple phosphates, epithelium, and a considerable amount of blood. The appearance of the man, and the fact that he had lost his voice, suggested that the trouble was of tuberculous origin, but no tubercle bacilli could be found in the urine. He was too ill to be operated on, and even attempts to wash out his bladder were always attended with great pain. He died a fortnight after admission to hospital. At post-mortem the base of the bladder was found to be occupied by several large villous masses, the largest being situated at the mouths of the ureters; the bladder wall was thickened, and the ureters greatly dilated. The kidneys showed the ordinary septic changes following cystitis.

Mr. L. G. **GUNN** spoke on the subject.

CARCINOMA FOLLOWING ULCER OF DUODENUM, WITH SECONDARY DEPOSITS IN LUNGS.

Dr. **BOXWELL** exhibited specimens with microscopic slides. The organs were obtained from a man æt. 60. He had been suffering for some years from attacks of jaundice, sometimes with slight vomiting, but never had much pain. An exploratory laparotomy was performed, and the gall-bladder was found to be distended, and a hard mass could be felt in the duodenum, while the pancreas was found filled with small hard nodules. The patient made no definite progress, and died in a week. At post-mortem it was found that there was something like an ulcer occupying the ampulla, just at the entry of the common duct, with a fair amount of new growth of a cancerous nature around it. Nodules were also scattered through the lungs; these were found to be carcinomatous, while the nodules in the pancreas were merely necrotic masses. The liver was simply jaundiced; there were no secondary deposits in it.

CANCER OF THE BLADDER.

Mr. L. G. Gunn exhibited a specimen showing extensive cancer, filling practically the whole interior of the bladder. The patient was a man who presented all the appearance of a very acute inflammation of the bladder. When the patient was first seen the disease was too far gone to allow of operative interference beyond giving relief by draining; the tumour was then about the size of a small tangerine orange. The man lived about two months, and in that time the bladder had filled up. The tumour was a very cellular carcinoma, and was unusual in not having any symptoms of hæmorrhage.

THROMBOSIS OF ARM WITH GANGRENE.

Dr. O'Carroll described a case of gangrene in a widow, æt. 39, who entered hospital in July last complaining of cramps in the fingers of her left hand. The day after admission a slight bluish tinge was seen, especially about the wrist, and she was unable to lift the forearm. Nothing in her history gave any clue to the cause of the condition. Her heart was found to be rather weak, with some slight softening of the first sound. The only objective defect to be found was a small quantity of albumen in the urine. Her chest was small; she was thin, and had a ruddy blue face. The day after admission pain was complained of in the right hand and arm, and a slightly black hue was found about the right wrist. Within a few days the circle moved up the left arm, while the right hand cleared up. The left hand gradually dried up, and became perfectly rigid, and in about three weeks the dryness and mummification had reached the junction of the upper and middle third of the forearm. The arm above this became swollen and tender, and presently a line of demarcation occurred, and sank in about a fortnight to a depth of about half an inch. The patient was given two or three minutes of anæsthesia, and the arm was taken off above the elbow joint. The stump healed perfectly, and she left hospital much better in general health.

Mr. H. Stokes referred to a somewhat similar case.

Professor White said he remembered quite well the case referred to by Mr. Stokes, which was so like that which Dr. O'Carroll had so graphically described. In it the gangrene was undoubtedly due to the condition of the vessels of the arm, which were rigid, and their lumina almost obliterated.

SARCOMA OF TIBIA.

Dr. G. Harvey showed a specimen of sarcoma of the tibia occurring in a married woman æt. 55. He exhibited at the same time several microscopic slides and X-ray photographs of the tumour. The latter showed certain points which were not evident in the specimen—viz., (1) that the fibula was free from the growth, (2) that there was no great expansion of the medullary cavity, but (3) there was great rarefaction of the head of the tibia, and (4) that the articular surface of the tibia was enlarged at its external margin. The growth did not appear to infiltrate the muscles very much, but rather pushed them in front of it. Microscopically, the tumour was in parts an ossifying chondro-sarcoma. In other portions round cells in alveolar grouping were to be seen. Two interesting questions arose: First, was this alveolar arrangement due to a segregation of cells into cartilage spaces, with partial absorption of the cartilage?—and might this be the general explanation of alveolar sarcomas, using the term in the descriptive sense? Second, did the sarcoma start in the centre of the bone or outside? From the appearances of the radiograms in conjunction with the fact that the tumour cells appeared to be grouped about the perichondrium, he inclined to the view that the growth originated outside the bone, probably from the cartilage of the point.

Professor White said he thought the appearances seen in one of the X-ray photographs were strongly in favour of the view that the tumour started inside the bone. The upper portion of the internal aspect of the tibia was completely destroyed, which simply meant that the tumour in making its way out destroyed the bone. The so-called expansion of bone simply meant that while the bone inside was being infiltrated and destroyed, new bone was being formed outside. A time always arrived when the new bone was not formed in sufficient quantity to cover the more rapidly growing tumour.

Mr. L. G. Gunn also spoke, and Dr. Harvey replied.

LARYNGEAL SPECIMENS.

Professor White showed and demonstrated a few interesting old specimens from the College of Surgeons' Museum.

(*a*) *Cases of Hanging.*—In two specimens obtained about 80 years ago the same lesions were present. In each case the thyroid cartilages and os hyoides are widely separated from each other—the intervening muscles, etc., having been almost completely torn across. The epiglottis was torn away from rest of larynx, and ascended with os hyoides and tongue into floor of mouth. In Vol. V. of the old *Dublin Hospital Reports*, a short description of these specimens is given. It would appear that the omo-hyoid, sterno-hyoid, and sterno-thyroid muscles were lacerated in such a fashion that only a few shreds held the torn portions together. The right sterno-mastoid was ecchymosed, contused and broken; while the left sterno-mastoid was but slightly bruised. The rope knot was to the left side. The skin alone intervened between the rope and the interior of pharynx. The cervical vertebræ and spinal cord were uninjured.

(*b*) *Suffocation.*—The specimen in this case showed a large lump of meat, almost three inches in length, firmly wedged in the pharynx and œsophagus, and completely closing the superior opening into larynx.

(*c*) *Ulceration of Tracheotomy Tube into Aorta.*—No history attached, but apparently the condition for which the operation of tracheotomy was performed was an acute one, as no disease of the larynx is recognisable. At a period long after the operation, but some time antecedent to death, some unskilful person attempted to replace the tube, but thrust it instead between the sternum and trachea, with the result that ultimately the lower end of tube ulcerated into arch of aorta. Judging from the appearance of the wound in the trachea, some time must have elapsed before this occurred. From the time the tube was put in the false position, the patient must have breathed in the ordinary way, as the tracheal wound was quite blocked by the tube in front.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held December 4th, 1907.

The President, Dr. James Ritchie, in the Chair.

Dr. W. G. Aitchison Robertson gave a demonstration of the method of sterilising milk by Buddisation. He referred to a previous communication concerning the state of the milk supply of Edinburgh, and said that the condition of matters had in no way altered for the better during the two years which had since elapsed. Budde's method of sterilising milk had proved commercially successful in Denmark, and a company had been formed to supply Buddised milk in Edinburgh. He did not himself believe that in the minute quantities which were required to destroy the germs in milk such preservatives as formalin or boric acid were deleterious, but any objection which existed to their use did not apply to Budde's process. He had found the germ content of Edinburgh milk higher than the standard of good quality in many cases. Buddisation consisted in adding peroxide of hydrogen (pure 3 per cent. solution) to milk at a temperature of 120° F. The enzymes, which are present in milk as well as all other living substances, decomposes the peroxide of hydrogen and sets free nascent oxygen, which acts as a germicide. In order completely to sterilise milk, .03 to .035 per cent. of hydrogen peroxide is added. This quantity is completely decomposed by the milk, and consequently there is no disagreeable taste. Milk so treated will remain sterile for a number of days. Mr. Budde, who was present, gave details of his process, and samples of the milk were on view, stored in the automatically stoppered bottles in which it is supplied commercially.

Dr. **Alex. Goodall** and Miss **Isabel Mitchell**, B.Sc., read a paper on

THE ACTION OF CERTAIN SALTS OF FORMIC ACID ON THE CIRCULATORY AND MUSCULAR SYSTEMS,

a full abstract of which will be found on page 634.

In the discussion that followed,

Dr. G. A. **Gibson** remarked that, from the results of clinical observation, he could not doubt that formic acid had a marked effect in raising the blood pressure. This he had frequently demonstrated in cardiac disease by means of the Riva-Rocci sphygmanometer. He was also convinced that in chorea the drug had a valuable tonic action on the muscles. Moreover, he believed that it was of use as a tonic. He had frequently noticed that patients who had felt the benefits of formic acid asked for more of the same tonic, though they were ignorant of its composition.

Dr. C. B. **Ker** also spoke favourably of its use in diphtheria. The mortality rate had diminished slightly since they had begun to use it systematically in the fever hospital, and the incidence of post-diphtheritic paralysis had diminished. Possibly the lessened number of cases of post-diphtheritic paralysis was due to the action of formic acid on muscular tissue. At present, in spite of Dr. Goodall's destructive criticism, he was inclined to go on using a remedy which was giving him good results. It was generally said that formic acid was apt to disagree, but he had noticed that in cases of cardiac vomiting, when nothing else could be retained except a little iced brandy, formic acid was well borne. In his cases diuresis had not been noticed.

In his reply Dr. **Goodall** spoke of the difficulty of reconciling clinical and physiological discrepancies. He had made no observations on the action of formalin on the metabolism, because he understood that the subject was being worked out elsewhere at present.

Mr. J. W. **Struthers** read a paper on

THE VALUE OF NOVOCAIN AS A LOCAL ANÆSTHETIC FOR SUBCUTANEOUS USE.

Novocain was a synthetic local anæsthetic which had already found many supporters, and the claims made for it were, he thought, well founded. After trying it in about 85 cases, he could say that it had proved uniformly satisfactory, and equal to, if not better than, cocaine and eucaine. It was soluble, stable, and sterilisable, and compatible with adrenalin. He preferred to make up a stock solution in bulk which was boiled each time before use. For infiltration anæsthesia he used a solution of 1.400, with 1 minim of commercial adrenalin solution added to every 2 drachms. This solution produced anæsthesia in about 10 minutes, and it lasted for from one to three hours. For inguinal anæsthesia, produced by injecting novocain in the neighbourhood of large nerve trunks, a stronger solution (2 per cent.) was employed, with 1 minim of adrenalin added to every drachm. The maximum dose of the weaker solution was 6 ozs.; of the stronger, ½ oz. A number of operations, such as avulsion of the nails, amputation of the fingers, cleansing lacerated wounds, incision of whitlows, etc., which had been satisfactorily performed under novocain, were referred to.

Mr. **George Chiene** and Mr. **Wheeler** (Dublin) discussed the paper, the former pointing out the great advantage of local anæsthesia in minor surgery. Fatalities from the anæsthetic were relatively far more common after minor operations, therefore general anæsthesia should as far as possible be dispensed with. Mr. Wheeler confirmed Mr. Struthers' estimate of the great value of novocain, and described his method of employing it. He injected it into the true skin, and found that anæsthesia was almost immediately produced.

In reply, Mr. **Struthers** said that while anæsthesia was almost instantaneous when the injection was made into the true skin, he preferred to give it subcutaneously, which delayed the action somewhat.

Dr. **Alexander James** read

NOTES ON CASES OF TUBERCULOUS ANÆMIA.

The condition had first been described by Trousseau; its characteristic was that along with the symptoms and appearance of anæmia there was found an almost normal appearance of blood. He gave notes of two cases in which the patients had complained for some time of pallor, palpitation, and breathlessness in exertion. They both looked markedly anæmic, but on examination of the blood an almost normal count was found. On further investigation evidences of phthisis were discovered. It was argued that the existence of chronic anæmia, without alterations in the blood, was suggestive of tuberculosis. Possibly, the anæmic condition was a factor in the development of the tuberculous diathesis. It was possible that the appearance of anæmia was actually due to a diminution in the total volume of the blood, and was associated with a condition of hypoplagia of the vascular system. Trousseau held the view that in these cases treatment of the anæmia was not very safe; he compared the need for care in giving of iron to these patients with the caution which must be exercised in checking leucorrhœal discharges, and in operating on fistula in tuberculous patients. It seemed to him that hæmorrhage from the lungs might develop on the administration of iron. With this old-fashioned view Dr. James to some extent agreed, and he quoted an example of the occurrence of signs of tuberculosis after treatment of an anæmia of this description with arsenic.

Dr. **Gulland** discussed Dr. James's paper.

Dr. **Alexander Bruce** read a paper on

UNUSUAL SEQUELÆ OF HERPES ZOSTER (?) POSTERIOR POLIOMYELITIS.

The patient in question had suffered from a severe attack of herpes zoster, followed after a short interval of time by a sensation of numbness, which passed up one lower extremity and down the other. Then followed muscular weakness of the right leg, with exaggeration of the deep reflexes and an extensor plantar response, and loss of pain and thermal sense with conservation of the lactile and muscular sense below the level of the herpetic zone. The secretion of sweat was also abolished over the affected limb. These symptoms—dissociated anæsthesia, muscular weakness, and exaggeration of the reflexes—subsequently spread to the left leg, and these gradually cleared up altogether. The sequence of events was suggestive of hysteria, but Dr. Bruce gave reasons for supposing that they were due to a hæmorrhage or other vascular lesion at the base of the posterior cornua, first on one side, and then on the other, a condition of posterior poliomyelitis

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CENTRAL MIDWIVES' BOARD.

Meeting held Thursday, November 28th, 1907.

The President, Dr. **Champneys**, in the Chair.

After a brief discussion as to the correctness of the designation of "midwife," and of the inability of the Act to suppress the practice of so-called "maternity nurses," it was agreed by the Board—(*a*) That the Home Secretary's proposal to extend the system adopted for reporting convictions of midwives within the area of the London County Council to the whole of the Metropolitan Police District, if desired by the other County and County Borough Councils therein, be accepted, with thanks; (*b*) that it be suggested to the Home Secretary that this system might with advantage be extended to the whole of England and Wales; (*c*) that the Home Secretary be furnished with particulars as to those Local Supervising Authorities who have not complied with Section 8 (5) of the Midwives Act, 1902, up to the present time.

A letter was read from Dr. W. P. T. Daniel, of 273, Cable Street, London, E., forwarding a copy of a resolution adopted at a meeting of medical men residing in the parish of St. George's-in-the-East, and neighbourhood, declaring their intention, after November 30th, not to proceed to any case of parturition, etc., occurring in the parish, on the requisition of a midwife, unless a minimum fee of one guinea is guaranteed either by the Guardians or by the Central Midwives' Board.

It was agreed—(*a*) that a copy of the correspondence be sent to the Privy Council, pointing out the difficulties and dangers of the situation, and suggesting that a copy of the Local Government Board's circular on the subject should be forwarded to every medical practitioner in England and Wales; (*b*) that the Board's action in the matter be communicated to Dr. Daniel, and that he be informed that the Board has no power to pay fees in such cases.

THE FEES OF MEDICAL MEN SUMMONED BY MIDWIVES.

Mr. Ward Cousins opened a discussion on the matter, reporting the question which had been put to him by the Royal College of Surgeons, as to what the Board was doing with regard to the question of the fees of medical men summoned to the assistance of midwives. He thought it was time the Board took some definite action. The whole efficiency of the Act was blocked by the absence of such official payment, and the consequent attitude of doctors. The Chairman said he thought the Board had done a good deal; it was out of their power to pay doctor's fees, or compel anyone else to pay them; but the importance of the matter had been constantly urged by them before the authorities, and he pointed to the recent circular issued by the Local Government Board, and sent to all the Local Supervising Authorities as a result of this agitation. He had great hopes from this circular, but it was quite new, and he thought it highly probable that a great many practitioners did not yet know of it. Dr. Stanley Atkinson said that St. George's-in-the-East was the only parish in London which had objected to complying with the suggestion of the Local Government Board.

Letters on the same subject had been received from Dr. E. Rowland Fothergill, Hon. Secretary to the Wandsworth Division of the Metropolitan Counties Branch of the British Medical Association, and from Dr. J. W. Hembrough, County M.O. for Northumberland. It was decided that the latter should be forwarded to the Privy Council.

At the request of the Local Supervising Authority for the Worcestershire County Council, it was agreed that Birmingham be constituted one of the Provincial Examination Centres during the pleasure of the Board.

Letters had been received from the Clerks to the Guardians of the Ashton-under-Lyne and Gateshead Unions, inquiring the reasons of the Board's refusal to approve their Union Hospitals as Training Schools for Midwives.

It was agreed that the Guardians be informed that the decisions were arrived at after a full consideration of all the facts bearing on the matter, and that it is contrary to the practice of the Board to give reasons for its decisions in such cases.

At their own request the names of 12 women were removed from the roll, on the grounds of old age, ill-health, or inability to comply with the rules.

Vacancies on the list of examiners to the Board were filled by the appointment of :—(1) J. P. Hedley, M.B., B.C. (Cantab.), M.R.C.P., Obstetric Tutor and Registrar, St. Thomas's Hospital; (2) Eardley Holland, M.D., B.S. (Lond.), F.R.C.S., Obstetric Registrar and Tutor, King's College Hospital, Assistant Surgeon for Diseases of Women, Metropolitan Hospital.

Applications for approval as Teacher were granted to the following:—Rosa E. Bale, L.R.C.P., L.R.C.S.; W. Fordyce, M.B., F.R.C.P.E.; F. G. Haworth, M.B.; G. F. B. Simpson, M.D., F.R.C.S.E.; S. H. Smith, M.B.; and of Penrose Williams, M.R.C.S., L.R.C.P.

Five midwives were approved to sign Forms III. and IV.

Dr. Stanley Atkinson was added to the Finance and Office Committee.

In the Secreary's report of the October Examination it appeared that out of a total of 461 candidates, 386 passed, leaving the percentage of failures 16.27. The London Training Schools had sent up 128 candidates, of whom 120 were successful. From the rest of the training schools in England, Wales, Scotland and Ireland there were 245 candidates, of whom 47 failed. The number of candidates trained by private tuition was 88, out of which 68 passed the examination.

The next general meeting of the Board will be held on December 19th, at 2.45 p.m.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Dec. 7th, 1907.

COLLOIDAL SILVER.

After a silence of several years, colloidal silver is once more placed on the *tapis*. Netter, in 1902, was the first to bring it under the notice of French surgery in an important communication made to the Medical Society. It was spoken of for some time, and finally fell into oblivion. Some medical men, however, continued to use it. Recently, some articles of Victor Henri and Iscovesco on colloidal silver, prepared by electricity, once more drew attention to this agent, and at the late Medical Congress several communications were made on the subject, presenting it in a very favourable light.

Silver can, like several other metals, such as mercury, gold, be obtained in a colloidal state. The reduction of salts of silver by different agents produces very easily colloidal solutions, but chemical processes give, all of them, impure products.

The electric preparation of colloidal silver, on the other hand, according to the method of Brédig gives absolutely pure products. Faraday proved that if an electric spark was given off in the air between two gold wires, a metallic deposit was obtained under the form of a very fine powder. It was by taking this principle as a basis that Brédig prepared a large number of colloidal metals.

The metallic solutions thus obtained, says Dr. Milian, are coloured more or less; they are clouded and yet leave nothing on the filter, nor with an ordinary microscope can any solid deposit be detected. With a powerful lens, however, a large number of brilliant particles can be seen, moving with great rapidity, and which are the metallic granules in suspension in the water.

One of the most important properties of these pseudo-solutions is that of giving a precipitate by an electrolyte of no matter what kind, provided it is employed in sufficient quantity; thus chloride of sodium precipitates a solution of colloidal platinum, and nitric acid precipitates silver colloidal.

Colloidal silver, called by Crédé collargol, appears under the form of small black grains easily crushed. It is employed in ointments, subcutaneous or intravenous injections.

The strength of the ointment is 15 per cent. It is utilised in the form of frictions like mercurial ointment. The skin being previously washed, the ointment is rubbed in for about ten minutes. These frictions possess a certain activity of absorption, but they are insufficient in grave cases. Subcutaneous injections should never be employed, as the solution (1—25) is absorbed very slowly, leaving hard nodules which take several days or weeks to disappear. The same might be said of intra-muscular injections.

Intravenous injections should be always preferred. Here absorption is rapid and complete. When the injection is properly made it leaves no trace, and its action is rapid and powerful.

The solution may be that of colloidal silver dissolved in water (1—100), but Dr. Milian prefers to employ electrargol, that is to say, collargol prepared by the electric method, as it is more active and more fluid.

The instrument employed is a syringe holding two drachms, as it may be necessary to inject that amount.

The bend of the elbow, where the veins are most visible, is the region to be chosen for the injection, and the preliminary preparations are those for blood letting: a bandage around the middle of the arm to arrest the venous circulation, antisepsy of the part by soap and hot water, and finally, with proof spirit. The operator, his hands being also rendered aseptic, seizes the needle, and only the needle between the thumb and index of the right hand, while with the left hand he fixes the vein by pressing on it with the thumb, he inserts it obliquely and gently into the vein. He knows he is in it by a drop of blood flowing out of the needle when he continues to push it in parallel to the vein. Then, holding the needle in the horizontal position, he fixes on to it the syringe and slowly injects the contents. No resistance should be felt during the injection, which if experienced, would result either from the needle being blocked up or that the liquid had penetrated into the cellular tissue. In either of these cases the operation should be stopped, the needle withdrawn and re-inserted into another vein.

These injections, made with the usual antiseptic precautions, are without danger; they are better borne than intra-muscular injections, and give truly wonderful results.

Asthma and Atropine.

Some 70 years ago, Trousseau recommended atropine in the treatment of grave cases of asthma, but this treatment fell into disuse, and yet deserves to be brought under notice again.

In a case of asthma of 20 years, for which different treatments had been applied in vain, including injections of morphia, atropine produced a prompt and durable effect.

The subjective condition improved, sleep returned, and the catarrh ceased. The treatment lasted six weeks. A quarter of a milligram was given twice a day at first, and gradually increased to two milligrams a day.

Certain very rebellious cases were not benefited, and sometimes troubles of accommodation and dryness of the pharynx were observed, but the heart was never affected. Naturally, the antispasmodic properties of atropine explain its action.

GERMANY.

Berlin, Dec. 7th 1907.

At the Medical Society, Hr. W. Braun spoke on

Penetrating Wounds of the Gastro-Intestinal Tract.

Last summer he had shown patients treated by himself in the Friedrichshain Hospital; first, two children with punctured wounds of the abdomen, victims of a crime that had aroused a great deal of excitement. One child, three years of age, had three penetrating wounds of the abdomen, from which intestine protruded, and in which the intestine was wounded in no less than eight places. In the other case, a child of five, the omentum protruded, but the intestines themselves were intact. To these were added four patients with gunshot wounds of the abdomen. In one case, that of a young girl, the bullet had penetrated from behind, had wounded the lower pole of the right kidney, and had then passed through the stomach, duodenum, and liver. The stomach and bowel were closed by suture; the kidney had to be extirpated on account of the continued bleeding that could not be arrested. Another patient who had severe injuries of the gastro-intestinal tract inflicted on the same occasion died. Two boys, aged 6 and 15 respectively, recovered.

The surgical experiences of the last war showed that in the case of abdominal wounds received from firearms in the field, expectant treatment gave the best results. The best war results were, however, wretched as compared with those obtained in a state of peace. Here it was decidedly better to treat at once, and the sooner the better. Undoubted signs of injury of intestine, such as vomiting, blood in the stools, or escape of fæcal matter from the abdominal wound, were not necessary, and in the cases shown were not present; but, on the other hand, symptoms of peritoneal irritation, such as nausea and abdominal tension, were present in every case. Where there was a possibility of a penetrating wound of the abdomen, the case should be attacked at once, provided the patient was in a properly equipped hospital. On widening the track of the wound, whether of knife or bullet, one can easily see whether the peritoneum was wounded or not, and in any case no harm would have been done.

Immediately on the infliction of the injury, spasm of the bowel took place; that at first closed the bowel and prevented the escape of fæcal matter; paralysis of the bowel did not take place till later, and then the escape of fæces was facilitated. Therefore, operation should not be delayed till the first shock was passed. Waiting might be very fateful for the patient, for the reasons that, first, the danger of peritonitis would be the greater the more abdominal contents had escaped, and, next, that suture of a well-contracted bowel was much more reliable than that of a paralysed one.

At the Otological Society Hr. Wagner showed a child in whom during the course of an attack of inflammation of the middle ear symptoms present in the fundus oculi were the main cause for chiselling the mastoid. The patient, a girl, gave the impression of being very ill, although both pulse and temperature were normal, and there was no tenderness over the mastoid. In the fundus oculi both the arteries and veins were engorged, and there was papillitis on the left, but no papillary stasis. At the operation a perisinuous abscess the size of a small hazel nut was found, and which was undergoing considerable pressure. After the operation the papillitis became still worse, but the vascular engorgement receded at once. Körner attributed this papillitis to a meningo-encephalitis.

Hr. Oertel related a case of

Serious Injury to the Skull.

The head of a little boy, æt. 3, was crushed between a mangle and the wall. The left side of the face at once became paralysed. A considerable quantity of blood escaped from the nose, mouth, and right ear for the next two days. After that, watery fluid came from the same ear, and a fortnight later pus flowed profusely. The external auditory canal was narrowed up to a small slit, out of which pus flowed when the child cried. Pressure on the mastoid, which was tender, also caused pus to flow from the opening.

An operation showed that a fracture had taken place in the lower portion of the squamous bone, and that a sequestrum, the size of a sixpenny piece, lay in the posterior wall of the auditory canal and was only connected with the other bony parts by a narrow bridge of osseous structure. The removal of the sequestrum led to speedy recovery from the traumatic mastoiditis. The left-sided facial paralysis was also beginning to disappear.

AUSTRIA.

Vienna, Dec. 7th, 1907.

Osteopathy.

Goldreich showed a child with an uncommon form of osteopathy due to syphilis, as was presumed at the May meeting, when he showed the child before treatment in the morbid state. At that time the differential diagnosis resulted in designating the case one of inhibited ossification, or osteogenesis imperfecta remotely depending on hereditary syphilis. At that time the ossification of the cranium was quite rudimentary, while there was inflammatory hyperostosis of the long bones which strengthened the syphilitic view. The same virus was considered active in stopping the growth of the flat bones of the cranium by some of the members, while others argued the opposite—that inflammatory hyperplasia was the rule in the bones of the head as well as the bones of the limbs. A more exhaustive examination revealed osteochondritis in the shoulder-blades and the elbow-joints, with pseudoparesis of the right arm.

After that examination the child was put on antisyphilitic treatment, with magical results, putting beyond doubt the proof that the affection was entirely due to the syphilitic virus.

The cranial defects soon closed, and the inflammatory hyperostosis of the long bones disappeared. It was subsequently discovered that the father had suffered from syphilis.

Spieler said he had a similar puzzling case two years ago, which he recorded in the *Zeitschrift*, and diagnosed it as probably due to hereditary syphilis.

Hochsinger said he had no doubt that the case was one of hereditary syphilis, as osteogenesis imperfecta, hyperostosis, etc., were peculiar to congenital syphilis.

Escherich thought that those belonging to osteomalacia were of a similar origin.

Cerebellar Tumour.

Marburg presented a case that originated a year ago in disturbance of vision, pain in the head of a rheumatoid character, unsteady gait, great increase of cranium, and a general growth of fat throughout the body. There was also congestion of the papilla and ataxia present. The tumour seemed to be located about the anterior portion of the superior vermiform process, causing dropsy of the third ventricles and degenerative changes in the hypophysis, the latter morbid condition accounting for the adipositas universalis, which has amply been demonstrated in cerebral changes.

Hochwart drew attention to the happy, gay, unconcerned state of the patient's mind, which he said was characteristic of cerebellar tumours.

Poliomyelitis.

Zupper next brought in a six-year child, with paralysis of both arms, including the shoulder muscles, with the exception of the levator scapulæ, trapezius and serratus magnus. All the muscles of the arms were paralysed with the exception of the flexor carpi ulnaris and flexors of the fingers. On the right hand the flexor of the thumb was also intact.

From this state it must be assumed that the lesion in the anterior horns of the cord cannot extend above the fifth, sixth, and seventh cervical vertebræ; but it must be noted the supra- and infraspinatus are involved in the general destruction, which have part of their origin in the fourth segment. This is worthy of note, as the phrenic nerve has its origin in the fourth segment, and remains perfectly entire. Another freak may be observed in the musculus serratus magnus, which arises in the fifth segment and is functionally entire. This case forcibly demonstrates how difficult it is to locate lesions of the cord with any approach to accuracy. Zappart said the prognosis was very unfavourable, even by orthopœdic means, although by a form of arthrodesis in fixing the shoulder and elbow, the boy could be made to raise the one hand to the mouth by the assistance of the other.

Moszkowicz thought a good deal could be accomplished in this case by means of surgical-orthopœdia, and exhibited a similar case he had operated on to demonstrate his assertion.

Abnormal Displacement.

Hochsinger interested the members with an unusual displacement of the heart below the ribs altogether, where the apex beat could be seen on the left side in the abdomen, while the upper margin of the cardiac area was delineated between the fourth and fifth ribs; towards the right the margin was two finger-breadths outside the sternum. Systolic and diastolic murmurs were found at all the ostia.

It appears that after an attack of endo- and pericarditis rheumatica, a mediastinal pericarditis supervened, fixing the pericardium to the anterior costal wall. The valvular defects and concretions subsequently caused hypertrophy and dilatation, but being fixed in its upper margin left no other retreat for the expansion than downwards and to the left in the abdomen, pressing the diaphragm before it into the abnormal position as seen in the patient.

HUNGARY.

Budapest, Dec. 7th, 1907

Physostigmine in Intestinal Paresis.

Not so long ago atropine was praised highly in all cases of intestinal obstruction depending upon paresis of the intestines. However, the director of the First Internal Clinic in Budapest, Prof. Koranyi, holds that physostigmine is much more suitable for such cases. Similar opinion was expressed also by Dr. Dollinger, Professor of Surgery. The latter gave in one instance where operation was refused and atropine given without the slightest effect. The patient was getting weaker and weaker, but after a subcutaneous injection of half a milligrame of physostigmine, rapid improvement set in. In some cases it will be necessary to give as much as one milligrame. The drug is not suited for children, but does good service if given by mouth for nervous flatulency and atonic meteorism.

The Efficaciousness of the Erysipelas Serum.

Dr. Révérf having applied the antitoxic therapy in cases of erysipelas, describes the results of his investigations in the *Orvosok Lapja*. He used the blood serum obtained from patients convalescing from erysipelas. The doses used were generally 10 to 30 c.c., sometimes 68 to 90 c.c., hypodermically. Nine cases were thus treated, including erysipelas of the face. As the result of this form of medication, headache, delirium, and hallucinations disappeared. The appetite improved, and the temperature fell in the majority of cases. Whenever albuminuria was associated with erysipelas, the antitoxin caused the disappearance of the former.

On the Internal Treatment of Appendicitis.

Dr. Szèkàcs settles the confusing diversions of opinion as to the proper time for operation in appendicitis in a simple manner. In mild cases he merely applies linseed poultices and administers 0.50 gr. of collargol, 100 c.c. of water, a tablespoonful every half hour. In more severe cases the dose is increased to 1.0 gr. in 100 water, and Credé ointment is applied locally. The drug also may be given per rectum where vomiting interferes. Sometimes a cure follows even where peritonitis has already set in, and of a large series of cases only two were lost since the peritonitis had already advanced too far when the patients were seen for the first time. Surgical intervention is only indicated where there is general peritonitis, and in these cases it is advisable to establish an artificial anus, and also to give large doses of collargol. This drug is harmless even if applied in very large doses.

The Sterility of Women.

Dr. Bäcker discussed the various forms of sterility in women at the last meeting of the Royal Interhospital Association. He cautioned his colleagues against the tendency to go ahead with the treatment of sterility on the assumption that it is due to the woman. In every case, he believes, the husband should be questioned as to his virile power, and a careful examination of his sperma should be made. This search for spermatozoa should be made several times, and at rather long intervals, during which time the person is to abstain from intercourse, since it is well-known that a temporary azöospermia occurs after repeated coitus. Dr. Bäcker read a report concerning 483 cases of sterility, in 58 of which absence of spermatozoa has been found. In nineteen of these cases the wives had been under treatment. Furthermore, he found in 37 instances persistent oligo-spermia, and 13 times necrospermia.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Treatment of Incipient Insanity.—Dr. Urquhart, the superintendent of James Murray's Royal Asylum, Perth, has written a letter to the *Scotsman* strongly supporting Dr. Clouston's appeal for the establishment of wards for the treatment of mild mental disorder. He instances the experience of the Albany Hospital, N.Y., in which on the petition of some physicians, a psychiatic pavilion was erected in 1902. It is a two-storeyed building containing 24 small rooms, 6 day rooms, and 2 dormitories, and since it was opened 1,031 patients have been admitted. Of these, 596 have returned to their homes recovered or improved, 316 have remained stationary, and 86 have died. More than half the patients were returned to their homes without the formidable apparatus of legal procedure, and the institution has become a general hospital turning none who are sick from its doors.

Proposed Model Hospital for the Scottish Exhibition.—In connection with the National Exhibition, which is to be held in Edinburgh next year, a letter was read at the last meeting of the Managers of the Infirmary, stating that it was proposed to have a home nursing section in connection with the woman's section of the exhibition. Lessons will be given in home nursing and the use of disinfectants. A request was made that the lady superintendent of the infirmary should be permitted to co-operate with the Exhibition Committee in arranging this exhibit. The letter was remitted for consideration.

Edinburgh Medico-Chirurgical Society. — An interesting meeting of this society was held on Wednesday last, when Dr. Aitchison Robertson gave a demonstration of the method of sterilizing milk by Buddisation; Mr. Budde, who was present, gave details of the process, and exhibited samples thus dealt with. The reading of papers followed, that by Dr. Goodall and Miss Mitchell on "The Action of certain Salts of Formic Acid on the Circulating and Muscular Systems" evoking considerable discussion. An abstract of this paper will be found in another column under the heading of "Original Papers." Mr. J. W. Struthers subsequently read a paper on "The Value of Novocain as a Local Anæsthetic for Subcutaneous Use," Dr. Alexander James one on "Tuberculous Anæmia," and Dr. Alexander Bruce one on "Unusual Sequelæ of Herpes Zoster." A report of the proceedings will be found under the heading of "Transactions of Societies."

BELFAST.

Queen's College.—The successful attainment of the objects for which the Better Equipment Fund was raised was marked by an interesting ceremony at the College last week, when a fine bronze tablet commemorating the services to the Fund of the Rev. Thomas Hamilton, D.D., President of the College, was unveiled. The unveiling was done by Mr. Justice Dodd, an old classmate of Dr. Hamilton's, and the chair was taken by the Right Hon. Thomas Sinclair. References to the University question were made by both these gentlemen, and hopes were expressed that the College might before long become autonomous.

Lurgan and Public Health.—A largely attended meeting was held in Lurgan last week, when it was decided to start a local branch of the Women's Health Association of Ireland. The inauguration of the new society will take place in connection with the visit of the Tuberculosis Exhibition to the town. Dr. Agnew, the Medical Superintendent Officer of Health, addressed the meeting.

Medical Inspection of School Children.—At the first meeting of the Public Health Committee of the Belfast Corporation, Dr. Henry O'Neill brought up the question of the desirability of having a system of medical inspection of school children in Ireland similar to that which is now coming into operation in England.

The Tuberculosis Exhibition.—In the course of the past fortnight, during which the Tuberculosis Exhibition was open in Belfast, it was visited by over 43,000 persons, and has proved in every way a great success. In the mornings and afternoons parties of visitors were conducted through the various rooms by young medical men who had volunteered for the duty; then afternoon lectures on sick-room cookery were given by a lady, and a series of evening lectures were delivered to crowded audiences. These lectures were as follows:—(1) Tuberculosis in Children, Dr. John McCaw; (2) Surgical Tuberculosis, Professor Sinclair; (3) Tuberculosis the Scourge of Ireland, Sir Robert Matheson; (4) Some Aspects of the Tuberculosis Problem in Ireland, Dr. David Lawson; (5) Stuffy Rooms: their Cause and Cure, Mr. Wm. Davidson, Belfast Technical Institute; (6) Tuberculosis in Animals, Professor Mettam; (7) How to Keep Our Homes Healthy, Mr. A. Savers, Belfast Technical Institute; (8) the Fight against Tuberculosis: what Other Countries have Done, Professor Lindsay; (9) the Prevention of Tuberculosis, Dr. Wm. Calwell; (10) Some Outstanding Effects of Tuberculosis, Professor Symmers; (11) Sanatorium Life Illustrated, Dr. Howard Sinclair. The exhibition was privately visited by her Excellency the Countess of Aberdeen, who made a special journey from Dublin for the purpose. She was conducted through it by the Honorary Secretaries, Drs. Thos. Houston and John MacIlwaine, to whom no small share of the credit for its success must be assigned.

Dr. Richard Barnett.—One of the oldest medical men in the district passed away last week in the person of Dr. Richard Barnett, who died in his sleep on his 79th birthday at his residence at Holywood, co. Down. Dr. Barnett studied in Edinburgh, where he graduated in 1849, and subsequently practised as a dental surgeon in England and the south of France, returning to his native city, Belfast, about 40 years ago, and practising here till his retirement in 1900. He was a singularly shy and retiring man, but came prominently before the public in two capacities, as a rifle shot and as a chess player, in both of which he obtained champion honours, as has his only surviving son, Mr. R. W. Barnett, a well-known member of the English Bar and of the Irish rifle team at Bisley. He was highly respected by his medical colleagues, and was for many years a vice-president of the Ulster Medical Society.

LETTERS TO THE EDITOR.

"THE BROWN DOG" DISTURBANCES.

Sir,—In your comment of November 27th *re* the "Brown Dog" and the students, you state the dog "was destroyed in a perfectly legal and regular manner." Allow me to correct this assertion. According to the Act of Parliament, "the animal must be killed immediately the object of the experiment is obtained." When this unfortunate dog, after an interval of two months, was opened a second time to ascertain if inflammation had been set up by the first operation, the object was obtained. But the dog was not killed; on the contrary, it was handed over, with wounds clamped with forceps, to a second vivisector, who performed upon it a severe operation lasting an hour. Even then it is a matter of doubt what further use may have been made of its mangled body, for at the trial a third person and also the laboratory boy both claimed to have despatched it. This may be "regular," alas! but it is certainly not legal.

I am, Sir, yours truly,
Frances E. White.

December 6th, 1907.

[We spoke simply of the death of the dog. It was killed in as legal and regular a manner as a bullock is killed in an abattoir. The plea about the second experiment done on the dog is beside the point altogether. It is mere juggling with words to make out that the demonstration given on the animal while it was under the anæsthetic and before it was killed was a transgression of the Home Office regulations. Would the anti-vivisectionists have preferred another dog to have been used instead?—Ed.]

To the Editor of The Medical Press and Circular.

Sir,—My attention has been called to a paragraph or two in an article in your issue of November 27th, *i.e.*, that "Animal experimentation provides the children of their borough" (*i.e.*, Battersea) "with the only means" (*sic*) "whereby they can efficiently be helped to recover when attacked by diphtheria." If you will take the trouble to look the matter up, carefully and without bias, you will find that some of the highest authorities, and perhaps, even especially vivisectionists, have by their expressed opinions traversed this misleading statement in your article. The rest of your article does not much concern me; but, in closing, I may say that your "Bullock" remarks will cause some astonishment in farming circles, proceeding from a pardonable want of knowledge of farming pursuits, operations, and objects. As regards your assertions about the different experiments on and death of the "Brown Dog" and the libel case to which you allude, it would be well not to confuse the two issues, and you might look this also up at the same time as you do the use of diphtheritic serum and certain farming operations.

Yours very faithfully,
George W. F. Robbins, Secretary.

Battersea General Hospital,
December 9th, 1907.

[We really cannot take Mr. Robbins seriously; to traverse his statements would be to do so. His advice to us to look up the literature of antitoxic serum in the treatment of diphtheria is a very poor joke. So, too, is his criticism of our knowledge of the castration of male animals on farms, and also of our delinquencies in the English language. With regard to the slander case in question, we are satisfied that a jury should have expressed their opinion of the veracity of anti-vivisection statements by awarding Dr. Bayliss £2,000 damages, and that the anti-vivisectionists proceeded to commemorate the occasion by putting up a public monument. A more striking testimony to the sense of truth and justice possessed by the organisers of the movement is hardly needed.—Ed.]

WHO INTRODUCED TRYPSIN?

To the Editor of The Medical Press and Circular.

Sir,—The letter from Dr. Shaw-Mackenzie, published in your last issue but one, contains a challenge as to the origination of the trypsin treatment of cancer that it will be impossible for the scientific world to ignore. The gentleman mentioned either is or is not the originator of the method. His statements are clear, and he has published the documentary and other evidence on which his claim is founded. On the other hand we have conflicting claims published for the most part in lay newspapers by Dr. Saleeby, a medical man, who asserts that Dr. Beard, a non-medical man, was the first to advance the theory. Dr. Shaw-Mackenzie states that he used trypsin and published a description before Dr. Beard. The matter can hardly be allowed to rest here, for some of our medical journals seem to have assumed that the honours do not rest with Dr. Shaw-Mackenzie. Surely no honourable man would decline his challenge to substantiate public statements as to the priority of claim.

Turning to another phase of the subject it seems curious that we should turn to Germany for information on the trypsin treatment, and quote freely the opinions of von Leyden on the point. We have no need for science "imported from Germany" while we have the original thing at home. Von Leyden is years behind Dr. Shaw-Mackenzie in this matter, yet we see von Leyden quoted copiously, while the prophet stands neglected in our midst. At present the scientific surgeons appear to be recognising that there is something of truth in Dr. Shaw-Mackenzie's patient investigations. It seems only reasonable to ask that the editors of medical journals should carefully examine the facts of the case before they accept the claims to priority on either side, especially when one of the rival claimants happens not to be a medical man.

Yours faithfully,
Onlooker.

London, W., December 8th, 1907.

THE MIDWIVES ACT.

To the Editor of The Medical Press and Circular.

Sir,—It is probable that most of us who have any knowledge of the ways and means of providing the poor with the proper care required when their children are being born will agree with the views expressed in the leader in the *Times* (December 7th); and it is quite clear that the Archbishop of Canterbury and Lord Balfour are perfectly incompetent to deal with this question. The *Times* seems to be at a loss to know what is best to be done. It thinks that it will be "necessary to appeal to Parliament for some modification of the stringency of the Act." It thinks that "the period has passed for any more waiting upon providence." This question is one that should and must be dealt with by our profession, and it would be interesting if you would take it up in The Medical Press and Circular.

I am, Sir, yours truly,
R. L.

PROPRIETARY MEDICINES.

To the Editor of The Medical Press and Circular.

Sir,—I heartily endorse every word contained in Dr. Hamilton's letter in your issue of December 4th. In May last I communicated a paper on "The Passing of the Prescription: some of its Causes and Effects," to the Therapeutical Society. The rules of that Society prevented me from publishing this paper in one of the weekly journals. At the present time it seems that the majority of the profession are simply playing into the hands of the manufacturers. As to these proprietary preparations, many of them are advertised in the daily and weekly newspapers at the expense of the profession, yet are largely ordered by the latter. Why medical men are such fools in their own interests I have never been able to understand. One thing is certain, that prescription-writing is greatly neglected in these days. Students are lectured on rare diseases, new and very often empirical modes of treatment, and intricate laboratory methods, but when they receive their diplomas they are often unable to recognise a common case of varicella or of rickets, and much less able to prescribe for such conditions. To put it broadly, the old-respected "family doctor" is going out of fashion, and a new order of "medical man," equipped with little more than a price-list of drugs put up in special forms, a book of recipes presented to him by some enterprising manufacturer, has sprung into existence. Such a state of matters is to be greatly deplored, but so long as medical men prescribe preparations that are advertised in the newspapers, and sold direct to the public, we cannot expect much else.

I am, Sir, yours truly,
James Burnet, M.D.

Edinburgh, December 5th, 1907.

MEDICAL LAW.

To the Editor of The Medical Press and Circular.

Sir,—The admirable editorials which appear with due frequency, and the letters of well-informed correspondents in your journal, ought by this time to have made your readers tolerably well acquainted with the state of medical law. Every one of your readers ought to know that very few clauses of the Medical Acts are of any practical value; that the penal clauses are in most cases useless; and that, when operative, there exists no authority charged with the duty of putting them in force. Prosecutions under Medical Acts never take place unless carried out entirely by private persons or by societies. It ought to be impossible under the present law for a quack to recover fees for professional services; but, as most County Court judges know nothing about medical law, it is not at all surprising, as in a case you report this week, to find a quack suing for fees and gaining his case in such a court. Quacks are, as a rule, too clever to need recourse to the law. They mostly get paid in advance, or take care to charge for "goods supplied," not for services. The goods may be a new nose, or an apparatus to make a crooked nose straight, an electric belt, or a certain cure for rupture in form of a truss; and if the patient consent beforehand to pay the sum agreed upon, it is probable that the law will in most cases help the quack to obtain the money, however exorbitant the charge. That medical law should remain in the shameful state in which it now stands must seem to outsiders disgraceful to the profession that tolerates it. Surely it is the duty of the profession to bring their case before the country and before Parliament. A Medical Law Reform Society, properly organised, and including the majority of those having valid claim to the title of leaders in the profession, would attract a very large amount of outside support. It would attract the support of the whole scientific world, of which doctors form so important a section; it would attract the support of lawyers, and in time, either by means of a Royal Commission or otherwise, the imperative necessity for new enactments would be brought home to the minds of statesmen capable not only of constructing the necessary legislation, but of placing it speedily upon the Statute-book.

I am, Sir, yours truly,
Common Law.

Lincoln's Inn, December 6th, 1907.

QUACK METHODS.

To the Editor of The Medical Press and Circular.

Dear Sir,—I would draw your attention to two pamphlets issued by "The Urillae Syndicate." Address, 31 and 32, King William Street, London, E.C.

To the Parochial Clergy.

Rev. and dear Sir,—The Urillae Syndicate ventures to send you the enclosed sample of "Urillae" in the anticipation and hope that you will make use of it in any suitable case coming under observation in the course of your visitation of the sick! It then goes on—

No restrictions with regard to diet are required; and total abstinence is not a *sine quâ non*.

A further sample will be sent on receipt of a stamp.

Then comes a second paper.—The Urillae Syndicate would deem it a great favour if particulars of cases were forwarded to 31 and 32, King William Street, London, E.C. Name, sex, age, address, occupation.

The above particulars will be treated as strictly private and confidential, and will in no event be made use of for advertising purposes.

1. Description of disease.
2. Duration of same.
3. How soon relief from pain was effected after first dose of Urillae.

These, Mr. Editor, are the essential points of these two extraordinary leaflets. You will notice that quackery has reached another stage, viz., that in which vendors of quack preparations are trying to create a further order of quack practitioners. Surely it is high time that we obtained our Royal Commission, and safeguarded the public against the experiments of unqualified practitioners.

Yours truly,
S. J. Ross.

Monkhams, Bedford.

OBITUARY.

CHARLES ROBERT DRYSDALE, M.D., St. And., M.R.C.P., F.R.C.S.

We record with sorrow the death of Dr. C. R. Drysdale, who passed away on December 2nd, in his 78th year. For many years Dr. Drysdale was a well-known figure in medical circles in London. He had been Physician to the Metropolitan Hospital, to the North London Hospital for Consumption, the Farringdon Dispensary, and to the Rescue Home. Dr. Drysdale was well-known for the interest he took in the limitation of families. He was ever outspoken on the subject, and at the time of his death was President of the Malthusian League. With him passes from the scene another of the links with the middle of last century, for it is only just short of fifty years since he took his first qualification.

ROBERT DE BRUCE TROTTER, L.R.C.P.Ed., L.F.P.S.Glas., LL.

We regret to announce the death of Dr. Robert de Bruce Trotter, of Perth, which took place at his residence on December 3rd. For the past three or four years Dr. Trotter has been ailing, but was in his usual health at the beginning of the week, and the end came rather suddenly. Born in Galloway 74 years ago, after receiving his elementary education, Dr. Trotter proceeded to the University of Glasgow, where he carried off many prizes. Subsequently he started practice in Northumberland, where he was for ten years prior to coming to Perth. In 1880 he went to the Fair City, and rapidly built up an extensive practice for himself. For twenty years he discharged the duties of Medical Officer to the General Post Office staff, Perth. In ambulance work he took a keen interest, was one of the founders of the St. Andrew's Ambulance Association in Perth, and always acted on its Committee. He was a former President of the Perthshire branch of the British Medical Association. Dr. Trotter was possessed of considerable literary talent, and, besides being the contributor of many miscellaneous articles, was the author of two well-known books, "Galloway Gossip," and a "Collection of Folklore" about Galloway.

SPECIAL ARTICLES.

MEMORANDUM ON MEDICAL INSPECTION OF SCHOOL CHILDREN.

The Board of Education have issued a Memorandum [Circular 576] on medical inspection of children in public elementary schools under section 13 of the Education (Administrative Provisions) Act, 1907, from which we extract the following:—

Scope and Purpose of the Act.—The Education Act, 1907, in so far as it concerns the medical inspection of school children, is the outcome of a steady movement of public opinion throughout the entire community. For some years past evidence has been accumulating that there exists in certain classes of the English people a somewhat high degree of physical unfitness, which calls for amelioration, and, as far as possible, for prevention. A consideration of the gravity of the need led to the conclusion that medical inspection of school children is not only reasonable, but necessary as a first practical step towards remedy, and the Board desire at the outset to emphasize that this new legislation aims not merely at a physical or anthropometric survey or at a record of defects disclosed by medical inspection, but at the physical improvement and, as a natural corollary, the mental and moral improvement of coming generations. The broad requirements of a healthy life are comparatively few and elementary, but they are essential, and should not be regarded as applicable only to the case of the rich. In point of fact, if rightly administered, the new enactment is economical in the best sense of the word. Its justification is not to be measured in terms of money, but in the decrease of sickness and incapacity among children, and in the ultimate decrease of inefficiency and poverty in after life arising from physical disabilities.

The powers and duties of a local education authority under Part III. of the Education Act, 1902, include the duty to provide for the medical inspection of children immediately before or at the time of or as soon as possible after their admission to a public elementary school, and on such other occasions as the Board of Education direct, and the power to make such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition of the children educated in public elementary schools; provided that in any exercise of powers under this section the local education authority may encourage and assist the establishment or continuance of voluntary agencies and associate with itself representatives of voluntary associations for the purpose.

Organisation.—The respective functions of the Board of Education and the Local Education Authorities are clearly defined by the Act. The duties thrown upon the Board consist in advising Local Education Authorities as to the manner in which they should carry out the provisions of the Act, and in supervising the work they are called upon to undertake; in giving such directions as may be necessary regarding the frequency and method of inspection in particular areas; and in considering and sanctioning such arrangements for attending to the health and physical condition of the children as may be submitted to them by individual Authorities. The Board will also collate the records and reports made by the Authorities and will present an annual report to Parliament. The duty of carrying out the actual inspection has necessarily been entrusted by Parliament to the Local Education Authorities, and not to the Board. Each authority must, therefore, in due course appoint such Medical Officers or additional medical assistance as may be required for the purpose. Some time must inevitably elapse before all Authorities have their arrangements in working order, but it should be carefully borne in mind that, although the work is begun gradually, the initial organisation established by each Authority should admit of such expansion as will secure the thorough and efficient administration of the Act.

After careful consideration, both of the present conditions of local sanitation and of the developments most likely to serve the economical and efficient administration of this important branch of pubilc work, the Board are of opinion that—

(*a*) In county areas the County Council, which is the Local Education Authority, should instruct their County Medical Officer, who will be responsible for smooth and effectual administration, to advise their Education Committee and to supervise the new work, its actual execution being deputed wholly or partly to suitable medical colleagues or assistants (men or women), who either will be appointed specially for the purpose under him or will be local Medical Officers of Health, and to whom groups of schools may be allocated. Where no County Medical Officer has yet been appointed under the Local Government Act, 1888, it would seem that the new duties in regard to medical inspection of children now imposed on the County Council will render it inadvisable any longer to postpone such an appointment, since in no other way will the Council be able effectually to secure adequate control, economy, and efficiency in carrying out their new work, which must obviously be guided from the central county organisation.

(*b*) In county boroughs the Town Council, which is at the same time both the Local Authority for Public Health and also the Local Education Authority, should instruct their Medical Officer of Health to advise the Education Committee and should make him responsible for the new work or for the supervision of such medical assistance as is needed to carry it out. Where appointments of school medical officers already exist, the Board do not suggest that they should be disturbed, provided always that the officers are competent and sufficient for the new duties and that the arrangements for supervision by the Medical Officer of Health are satisfactory.

(*c*) In non-county boroughs and urban districts which are Local Authorities for elementary education, the desirability of ultimately making similar arrangements, separately or in combination with contiguous districts, should be kept in view, though for the time being some variation may be requisite in accordance with local needs and circumstances.

Generally speaking, the work of inspection should be supervised by the Medical Officer of Health of the Authority which appoints the Education Committee; and when the work is obviously more than he can undertake unaided it should be entrusted to one or more medical officers working under his supervision. When it is necessary to appoint officers for the purpose of the Act, it is extremely important that persons of suitable qualifications and experience should be selected, even though they may not be called upon to give the whole of their time to these duties, and it should be noted that there are many cases in which women are likely to be specially suitable. In making such appointments preference should be given to medical men and women who (1) have had adequate training in State Medicine or hold a diploma in Public Health, (2) have had some definite experience of school hygiene, and (3) have enjoyed special opportunities for the study of diseases in children. The particular needs and circumstances of the area or group of schools concerned should receive due consideration, and great care must be taken to see that school hygiene really forms an integral and fundamental part of the public health adminstration of the district, and is not subordinated to other less important sanitary questions.

Subsidiary Agencies.—The Board are convinced that the work of medical inspection cannot be properly accomplished by medical men without assistance. The teacher, the school nurse (where such exists), and the parents or guardians of the child must heartily cooperate with the school medical officer.

Character and Degree of Medical Inspection.—From what has been said it will be clear that the fundamental principle of section 13 of the new Act is the medical examination and supervision not only of children known, or suspected, to be weakly or ailing, but of all children in the elementary schools, with a view to adapting and modifying the system of education to the needs and capacities of the child, securing the early detection of unsuspected defects, checking incipient maladies at their onset, and furnishing the facts which will guide Education Authorities in relation to physical and mental development during school life. The character and degree of medical inspection will depend on the standpoint from which the subject is viewed, the difficulty being, of course, to attain a due sense of proportion and uniformity, particularly as to fundamental points. Valuable to science though the findings of a more thorough and elaborate medical examination might be, it is the broad, simple necessities of a healthy life which must be kept in view. It cannot be doubted that a large proportion of the common diseases and physical unfitness in this country can be substantially diminished by effective public health administration, combined with the teaching of hygiene and a realisation by teachers, parents, and children of its vital importance. The spread of communicable diseases must be checked; children's heads and bodies must be kept clean; the commoner and more obvious physical defects, at least, must be relieved, remedied, or prevented; schoolrooms must be maintained in cleanly condition, and they must be properly lighted, well ventilated, and not overcrowded; the training of the mental faculties must not be divorced from physical culture and personal hygiene.

Regulations.—The Board have decided, under section 13 of the Act, that *not less than* three inspections during the school life of the child will be necessary to secure the results desired. The first inspection should take place at the time of, or as soon as possible after, admission to school; the second at or about the third year (say, the seventh year of age); and the third at or about the sixth year of school life (say, the tenth year of age). A further inspection immediately before the departure of the child into working life would be desirable where practicable, and in some areas it may be best for this to take the place of the third inspection. Certain adjustments will be necessary in working out any standard in practice, as it will at once be evident that without such adjustment the first year (1908) would be unduly burdened with the inspection of the children newly admitted and of all the children already in school.

Amelioration and Physical Improvement.—The aim of the Act is practical, and it is important that Local Education Authorities should keep in view the desirability of ultimately formulating and submitting to the Board, for their approval under section 13 (1) (*b*) of the Act, schemes for the amelioration of the evils revealed by medical inspection, including, in centres where it appears desirable, the establishment of school surgeries or clinics, such as exist in some cities of Europe, for further medical examination, or the specialised treatment of ringworm, dental caries, or diseases of the eye, the ear, or the skin. It is clear that to point out the presence of uncleanliness, defect, or disease does not absolve an authority from the consequent duty of so applying its statutory powers as to secure their amelioration, and to prevent, as far as possible, their future recurrence or development. The subject of specific medical treatment is, however, one which will require subsequent consideration in the light of the findings of medical inspection and the collateral issues raised thereby, and it is clear that, speaking generally, Local Education Authorities will be unable to formulate and submit for the Board's sanction any comprehensive scheme for the furtherance of this object until they have considered the results of their medical inspection in various directions.

This Circular is of a preliminary nature only, and concerns almost entirely the work of the new Act at its initiation.

REVIEWS OF BOOKS.

SURGICAL INSTRUMENTS IN GREEK AND ROMAN TIMES (a).

DR. MILNE is certainly to be congratulated on his book, "Surgical Instruments in Greek and Roman Times," for it enlightens us on a subject on which up to the present little or no collective work has been done. As it is, his volume forms a high testimonial to his skill and learning, and it will be a source of much pleasure to those who delight in medical archæology. The task the author has undertaken is one which might well have appalled anybody but a man of leisure, and we can only say that it is highly creditable to the industry of a practitioner that he should have been able not only to pursue all the literary research necessary to the elucidation of the shape, size, and purpose of surgical instruments among the Greeks and Romans, but also have managed to visit all the collections on the Continent and photograph the actual specimens. We doubt if there is anyone in a position adequately to criticise Dr. Milne's judgments as to the purpose for which the instruments were designed; for ourselves we may say that they strike us as sound and well thought out, and in some cases where he differs from other authorities, notably in the case of the lithotomy knife described by Celsus, he carries us with him. His explanation and design of this instrument are as convincing as they are ingenious. To those unread in medical lore it may be a surprise to learn how large a surgical armamentarium the classical nations possessed, and what a variety of operations they undertook; but perhaps the most striking thing is that Hippocrates should have been probably the most accomplished as well as the earliest of the surgeons of whom we have definite record. The photographic plates, 53 in number, which accompany the text, are beautifully executed, but it is rather a pity that Dr. Milne has not named the various instruments *in situ*. That, perhaps, is more of a lazy man's objection than a really critical point, but we feel a slight actual grievance in the fact that so scholarly a man as the author should habitually use such a solecism as "a forceps." However, the book all through is a mine of interest, and in the name of the profession we offer our warm thanks to Dr. Milne for having made available to his less fortunate brethren so fascinating a mass of information.

TRAVELS THROUGH FRANCE AND ITALY (a).

THE author being a medical man, suffering at the time from a chronic lung affection that ultimately carried him off, his letters possess a special interest for medical readers, although, in truth, he does not seem to have practised the healing art, having achieved a considerable measure of success in literature. Broken down in health, and mercilessly pursued by political enemies, he started in 1763 for Boulogne, *en route* for Montpellier, which was then apparently the most popular health resort in Southern Europe. On the way, however, he met an officer who recommended Nice, the climate whereof was "favourably spoken of with respect to diseases of the *breast.*" Passing through Montpellier on his way thither, he notes that "the air is counted salutary in catarrhous consumptions from its dryness and elasticity, but too sharp in cases of pulmonary imposthumes" (abscesses). Poor Smollett saw everything *en noir*, and bitterly complains of things in general and of French people and their ways in particular. Needless to say that the author of "Roderick Random" points his gibes with the skill of a master hand, so that his narratives are interesting as well as instructive reading. It will surprise many to find that doctors as far back as the middle of the eighteenth century talked of tubercles in the lungs and their breaking down (page 97), which, being absorbed, render the blood "acrimonious."

(a) "Surgical Instruments in Greek and Roman Times." By John Stewart Milne, M.A., M.D. Aberd. With illustrations. Oxford: At the Clarendon Press. 1907.

(a) Smollett's "Travels through France and Italy" is a recent addition to the admirable series of "The World's Classics," issued by the Oxford University Press.

MEDICAL NEWS IN BRIEF

Disputed Claim.

BEFORE Judge Parry in the Manchester County Court, on December 3rd, Drs. Vipont Brown, J. Darrington Willis, and Arnold Gregory, who practise in partnership in West Gorton, sued a tram-driver named T. C. Zlatano for £3 5s. for attendance on the defendant's child. When the case was originally before the Court the defendant said the reason he had not paid the bill was because Dr. Gregory, who attended his child, had been negligent.

Dr. Gregory, who attended the child from July 9th to July 18th last, said that upon the symptoms he diagnosed the case as pneumonia, with the possibility of meningitis suggested. By means of cold baths, packs, and sponging, he succeeded in reducing the temperature. Eventually the defendant called in another doctor. Cross-examined, he denied that the child was kept in bed without any covering until July 18th on his suggestion, and that it was unscious for more than two days.

Dr. Vipont Brown said that in his opinion Dr. Gregory's treatment saved the child's life. There was not the slightest doubt that the child was suffering from inflammation of the apex of the right lung.

Dr. Reynolds agreed that the symptoms of the child's illness indicated pneumonia. The treatment given by Dr. Gregory was the only proper one under the circumstances.

Mr. Hislop submitted that the ministration of the plaintiffs had the result of leading the defendant's daughter to the point of death.

His Honour: You must not say things like that, because the evidence at present is that the effect of the treatment was to bring her back to life.

Mr. Hislop: I am suggesting he was grossly negligent.

His Honour: You might just as well say a lawyer is grossly negligent if he doesn't win his case. If that were so, 50 per cent. of the lawyers who come here would be grossly negligent.—(Laughter). If you like, you may suggest that Dr. Gregory did not use a reasonable degree of skill and care.

Dr. A. W. Martin said he found all the symptoms of meningitis. If there had been pneumonia, it was only secondary.

His Honour: Are you prepared to say that in your opinion Dr. Gregory did not treat the case with a reasonable degree of care and skill?—All I can say is that the treatment was not what I myself would have adopted. I cannot say it was wrong or improper, because each doctor has his own methods. He treated it very much as nearly all doctors do.

Mr. Hislop: In face of this I don't think I can carry the defence any further.

His Honour: No, you cannot. You, too, are only expected to treat your case with reasonable skill and care.—(Laughter.) It was a hopeless case from the first. There must, therefore, be judgment for the plaintiff for the amount claimed, with costs.

Mr. Hislop pointed out that the defendant was a poor man, and asked for time in which to pay.

His Honour: That is just like a defendant. He first won't pay the doctor, then he blackguards him, and then says, "I want his mercy and plenty of time." However, I don't suppose Dr. Gregory has any vicious feeling. He is bound to justify himself. So I shall make a small order for payment at the rate of 10s. a month.

Death under an Anæsthetic.

DR. F. J. WALDO held an inquest on Saturday on a man aged 38, who died at Guy's Hospital while under the influence of an anæsthetic. After the operation was finished, the wife was asked to come and see her husband, as another slight operation had been found necessary, but before she could start she received a telegram informing her that he had died.

John Sefton Cooper, house surgeon at Guy's Hospital, said deceased was being treated for cancer of the tongue. He consented to the final operation being performed, and Mr. Smith—a clinical assistant, though a fully qualified man—administered the anæsthetic.

Henry J. Smith said he had been a qualified medical man since June 1.

Were you appointed to give anæsthetics among your duties?—Clinical assistants are supposed to give anæsthetics when they are called upon to do so. The witness added that there were eight anæsthetists in the hospital who would deal with the worst cases. His opinion was that death was due to a sudden dilatation of the heart, caused by coughing.

Dr. Theodore Fisher, an expert pathologist, called in by the Coroner to make a post-mortem examination, said there was nothing in the organs to show that the anæsthetic had anything to do with the death.

Mr. Philip Turner (acting resident surgical officer) said that at the present time there was a large committee sitting at Guy's Hospital to inquire into the whole question of anæsthetics. He believed that surgeons, anæsthetists, and the governors were all represented on that Committee.

The Coroner said, with regard to Guy's Hospital, that this was the thirty-eighth inquiry he had held into the cause of deaths of persons who had died while under the influence of anæsthetics.

The jury returned a verdict of death from misadventure.

London Hospital.

The quarterly Court of Governors was held on December 4th, Mr. Sydney Holland presiding. The Committee reported that the Queen, President of the hospital, since the last meeting had sent a donation of £666 13s. 4d. to the general funds of the institution. In recommending for election two dental surgeons, the Committee had considered it advisable that the department should be opened on every week-day instead of only four times a week. While it was satisfactory to note that the hospital was not in debt, the cost of the upkeep was £100,000 a year, and the assured income from investments and other funds was scarcely £20,000. Without the promissory income there was a balance of £40,000 a year which had to be raised. Among the list of donations was an item of £200 which had been received from Messrs. Clarke and Robinson, the owners of Demure, who won the Cesarewitch. Before the race the owners promised that donation in the event of the horse's winning. In moving the adoption of the report, the Chairman eferred to this contribution, and hoped the laudable xample would be copied by the Jockey Club and others interested in racing. The motion was seconded by Sir F. Young, and adopted. The Chairman said next year would be their quinquennial appeal, which he trusted would be responded to in a liberal manner.

t. Bartholomew's Hospital—New Pathological Wing.

Lady Ludlow, who was accompanied by Lord Ludlow (treasurer of the hospital), laid the foundation-tone of a new pathological block, which is to be rected on a site adjoining that of the medical school, nd facing Smithfield. The ceremony was attended by most of the members of the medical and surgical staff, nd many other friends of the hospital. The Clerk of he hospital, on behalf of the governors, read an address to Lady Ludlow. The address stated that the uilding was to be devoted to investigations in pathoogy and in pharmacology. The discoveries thus made nd the observations recorded would be of benefit to atients, whether within the hospital or without, hroughout the world. The address also alluded to he administration of Lord Ludlow, as treasurer, hich, it pointed out, had been of the greatest benefit St. Bartholomew's, while his period of office would always commemorated by the many new buildings ected. The new building is to be erected at a cost £30,000, and a special appeal is to be made for at amount.

ommittee of the London Ambulance Service.

The Committee appointed by the Secretary of State or the Home Department to inquire into the question the ambulance provision for cases of accident and udden illness occurring in streets and public places the Metropolis met at the Home Office on December 6th, Sir Kenelm Digby (chairman), presiding. Evidence was given by Mr. Samuel Osborn, F.R.C.S., chief surgeon of the Metropolitan Corps of the St. John Ambulance Brigade, the Hon. Sydney Holland, chairman of the London, Poplar, and Tilbury Hospitals, and deputy-chairman of the London and India Docks Company, Mr. F. W. Higgs, M.B., B.S., acting resident medical officer, St. George's Hospital, and by Dr. Henri Nachtel, of Paris. Any communications on the subject of the inquiry may be addressed to the Secretary, Mr. A. L. Dixon, Home Office, Whitehall, S.W.

Notification of Births Act in Dublin.

At the last meeting of the Corporation of Dublin, the Lord Mayor moved the adoption of the Notification of Births Act. Dr. McWalter opposed the adoption, and suggested that the question be deferred for twelve months, as it would entail extra expense on the Sanitary Department and was of doubtful utility for the conditions prevailing in Dublin, where excessive infantile mortality was mostly due to mere poverty. The consideration of the question was eventually deferred for one year.

Public Medical Service in Birmingham.

Another meeting of Birmingham doctors was held last week at the Medical Institute for the purpose of considering the proposals for the establishment of a public medical service. After prolonged discussion the meeting decided that it would not be advisable to establish the proposed service in Birmingham, the voting being 27 for and 60 against.

PASS LISTS.

University of London.

The following candidates have passed the M.B., B.S. Examination:—

Honours.—Richard H. C. Gompertz, B.Sc. (*a*, *d*, University Medal), T. S. Higgins, B.Sc. (*b*), James L. Lawry (*d*), Elizth. H. Lepper (*b*), Alfred Richardson (*a*), Clare O. Stallybrass (*c*, *d*), Leonard H. Wootton, B.Sc. (*d*), Andrew J. M. Wright (*a*, *d*).

(*a*) Distinguished in Medicine.
(*b*) Distinguished in Pathology.
(*c*) Distinguished in Forensic Medicine and Hygiene.
(*d*) Distinguished in Surgery.

Pass.—Samuel H. C. Air, Edgar Alban, Ardeshir P. Bacha, Laurence Ball, Frederick J. F. Barrington, Walter R. Bristow, Thomas E. A. Carr, Herbert S. Chate, B.Sc., Meyer Cohen, Walter F. Corfield, Ernest M. Cowell, Davis W. Daniels, Eleanor Davies-Colley, Eric J. De Verteuil, Carel C. A. De Villiers, Reginald L. E. Downer, Kenneth E. Eckenstein, Marmaduke Fawkes, Charles H. Fielding, Vera Foley, Arthur Fothergill, Ernest C. Hadley, John Hadwen, B.Sc., Eric H. R. Harries, Claud S. van R. Harwood, Herbert Hawker, Geo. M. W. Hodges, Edward H. Hugo, Douglas W. Hume, John P. Johnson, Henry T. Jones, Edgar H. Kettle, Clement Lovell, Eleanor Lowry, Emily M. S. Mecredy, Humphrey Nockolds, Evelyn H. B. Oram, Basil T. Parsons-Smith, Walter Patey, John G. Phillips, Jeffrey Ramsay, Samuel S. Rendall, Russell J. Reynolds, William Scarisbrick, B.Sc., Shantaram R. Shirgaokar, Marie Simpson, Eliza M. Smith, Horace E. R. Stephens, Robert Y. Stones, Arthur A. Straton, Reginald S. Townsend, Alfred G. Tresidder, Harold S. Vivian, Cuthbert G. Welch, Ruth H. Western, Henry Whitehead, Harold W. Wilson, John Black F. Wilson.

The following have passed in one of the two groups of subjects:—

M.B., B.S. Examination.—Group I.—Charles A. Basker, Janet M. Fishe, Susie E. Hill, Laura G. Powell, Mona D. Roberts, Frederick G. Sergeant, Thomas G. S. Smith, John J. Suckling, Cuthbert F. Walker.

Group II.—George N. Bartlett, Stanley J. A. Beale, Alfred Bernstein, John W. Bride, Herbert R. Davies, Clara Eglington, Frederick P. Fisher, Charles T. Hawkins, Maurice J. Holgate, John B. Martin, Alexander M. Pollard, Ethelbert W. Squire, Hugh Stott, Arthur L. Yates.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for **The Medical Press and Circular.**

RECENT MEDICAL LITERATURE.

Para-Nephritic Abscess.—Halsey reports a case of this rare affection, the patient, a man of 22, contracted a gonorrhœa eight weeks before admission. He was also under treatment for syphilis, which he had got about a year previously. Four weeks before admission pain began in his back, at first on the left side and later on, as the pain became more severe, spreading to the right side also. In the four weeks he had lost seven pounds weight. His inguinal and femoral glands were very much enlarged, those on the left side were exquisitely tender. There was no rigidity of the recti muscles, but deep pressure in the left hypochondrium caused pain. His temperature was 104, his pulse 116, urine showed no casts, no albumin, no indican, cystoscopic examination of the bladder revealed nothing abnormal. Ten days after admission to hospital he developed spasm of the left psoas muscle, which prevented him completely extending the left thigh, and soon after a slight bulging appeared in the left lumbar region, just below the ribs, and it was thought that a retro-peritoneal abscess was present. By an incision at the outer edge of the erector spinæ muscle a large amount of pus was evacuated, the kidney could be felt above the abscess, which was behind the peritoneum and external to the psoas muscle, and evidently external to the peritoneum. The patient's recovery was uneventful. It is interesting to note what was the probable course of the infection in this case, while the ureter and bladder were free from infection, the lymph glands were undoubtedly the path by which the infection travelled to the deep lumbar glands, those lying upon the psoas muscle being obviously the most vulnerable. Enlarged because of the syphilitic infection, the superadded gonorrhœal infection was too great, and an abscess formed; in reality this might be called a bubo inferior to the left kidney. The complete absence of any kidney irritation is also worthy of note. G.

Treatment of Tumours of the Central Nervous System.—Oppenheim (*Berlin Monograph*, 1907) says the prognosis of brain tumours is far more unfavourable than the prognosis of tumours of the spinal cord. In the former cases, the author noted only 11 per cent. of recoveries, and over 50 per cent. of failures, which must be designated as the results of operation. The surgical treatment of tumours of the spinal cord had resulted in permanent cures in about 50 per cent. of the cases so treated. The prognosis in the author's cases was made considerably worse by the fact that a proportion of 44 per cent. of his brain tumours belonged to the group of tumours of the posterior cranial fossa, and the prognosis in such cases is always unfavourable. From his statistics it appears that in only about one case out of ten carefully selected cases of brain tumour is operation likely to result in permanent and complete cure. The author believes that in the near future the surgical treatment of tumours of the spinal cord will be employed far more frequently, and that in consequence the prognosis will be greatly improved. Exploratory laminectomy should be done far oftener than it is, as it affords the only true means of recognising operable tumours in many cases where a positive diagnosis is prevented by the symptoms being very obscure. In such cases it is nearly always necessary to incise the dura, and the operator should never hesitate to do this,—indeed in most cases it is clearly indicated. The author believes that the operation of laminectomy is attended with comparatively no danger, and from observations made on his own cases at a considerable time after such operations, it seems that the patient suffers little or no weakness or inconvenience from the removal of several of his laminæ. G.

Frequency of Micturition in Women.—*The Hospital*, July). In women of middle age frequency of micturition is by no means uncommon. Inquiries should always be made in such cases if the frequency is by night as well as by day. In some cases of prolapsed uterus the frequency is markedly present in the day time, but almost absent at night when the patient is lying down. All such cases of frequency come under one or other of the following headings:—(1) Those cases which depend on some change in the urine; (2) those cases which depend on some condition outside the bladder; and (3) those cases which depend on some actual disease of the urinary tract from the kidney downwards. The most common cases are those which depend on some change in the urine, such as excess of urates, or excess of phosphates, and hyperacidity. In such cases diet, digestion, and a sedentary occupation are often responsible for the condition, and when they are remedied relief from the frequency will follow. The common lesions outside the bladder are tumours on the fundus of the bladder, early pregnancy, prolapse of the uterus, unilateral pelvic cellulitis, and pelvio-peritonitic adhesions. For such conditions citrate of potassium, hyocyamus and chloroform will often be of use. The third group of cases may require the cystoscope for their diagnosis, although even here the cystitis can be discovered by careful urinary examination. It is well to bear in mind that mild cases do not call for lavage of the bladder. Besides prolapses, vaginal discharges or dirty catheters may cause cystitis. Calculus, tuberculous ulceration, malignant growths, papillomata and varices at the neck of the bladder are rare, and require the cystoscope for their differential diagnosis. Stone in the kidney, renal growths, Bright's disease, diabetes, movable kidney, pyelitis, pyonephrosis, and tuberculous disease of the kidney may all cause frequency, and must be borne in mind; repeated and careful examinations of the urine and kidneys will in most cases enable a diagnosis to be formed. G.

Case of So-called Traumatic Asphyxia.—Beatson (*Glasgow Med. Journ.*, Nov., 1907) reports a case of traumatic asphyxia in a man æt. 24. He had been crushed antero-posteriorly by a pit cage, and his shoulders driven downwards and forwards into the abdomen and pelvis. There was intense congestion of the head and neck, almost petechial in character, but not affected by pressure. There was considerable œdema around the eyes and mouth. Sub-conjunctival hæmorrhage was considerable, and there was a large sub-lingual hæmatoma. There was also a probability of some hæmorrhage into the orbit, as there was some ptosis. There was no fracture. In three days the congestion and discolouration began to fade, and by the eighth day this was only present in the forehead, where it now yielded to digital pressure. There was discolouration around the eyes and nose, as in ecchymosis. In a short time all the discolouration had disappeared. S.

Movable Kidney from a Surgical Standpoint.—Billington (*Brit. Med. Journ.*, Nov. 30th, 1907) describes an operation for movable kidney which he has employed with success 70 times. The skin incision is parallel to the erector spinæ, and starts a little above and just behind the tip of the twelfth rib. The kidney is brought out into the loin. All adhesions, which are often of great density, should be cut with a scissors curved on the flat, so as to leave the kidney attached by its pedicle only. A triangular piece of kidney capsule is raised from the kidney. The apex of this flap of capsule is taken from the upper pole of the kidney. The base is left attached, and extends from the hilum to the centre of the convex border of the kidney. Two stout strands of silkworm gut are now passed beneath the unraised capsule in the way described by Goelet. The free ends of the silkworm gut sutures and the apex of the loose piece of capsule are clamped with a pressure forceps, and the kidney replaced in the loin. The upper part of the anterior surface of the quadratus lumborum is cleared, so that the kidney, when fixed in position, shall be against the muscle itself. The final fixation is now proceeded with. A pair of closed Spencer Wells forceps is forced through the muscles of the eleventh intercostal space immediately behind the tip of the twelfth rib, and made to seize the apex of the triangular piece of loose capsule. The kidney is pushed up from below until the base of the denuded area is on a level with the lower border of the twelfth rib. The loose strip of capsule is then drawn taut, and fixed by means of fine silk to its own base. In this way the kidney is suspended by a loop of its own capsule, which passes completely round the rib. Both ends of the two silkworm gut stitches already mentioned are made to pass through the ligamentum arcuatum externum, and through the skin about one inch above the skin incision. They are tightened and tied over a gauze pad. The skin stitches are removed at the end of a week, but the supporting stitches are left in for three weeks. The patient is kept in bed for a month, and then provided with a light belt or an elastic webbing bandage applied in the form of a spica which is to be worn for six months. S.

A Simple Operation for Uncomplicated Oblique Inguinal Hernia.—Chiene (*Brit. Med. Journ.*, 16th November, 1907) describes an easy and quickly performed method of operative procedure for the above condition. It can readily be done under a local anæsthetic. The author has employed it in 16 cases during the last 18 months with very satisfactory results. The skin incision is made half an inch above and parallel to the middle third of Poupart's ligament, the centre of which corresponds to the position of the internal abdominal ring. The external oblique is divided in the direction of its fibres, and the cremasteric muscle fibres are divided in the same direction. The internal oblique and tranversalis are retracted upwards and outwards, and the tranversalis fascia divided in the same direction as the external oblique. The neck of the sac is thus exposed at the internal ring. It is freed from the cord, opened and divided. The neck is ligatured and fixed to the under surface of the abdominal wall above and external to the internal abdominal ring, the rest of the freed portion being cut off. The split fibres of the external oblique are then sutured by the over-lapping method. In some cases the divided cremasteric fibres require a stitch to bring them together. The internal oblique and tranversalis therefore are left untouched, and the sac, with the exception of a small portion at the internal ring, is left *in situ*. S.

The After-History of Two Cases of Inter-Scapulo-Thoracic Amputation for Sarcoma.—Thomson (*Edinburgh Med. Journ.*, November, 1907) details two cases showing the sad contrast of the after-history in sarcoma of the shoulder to the brilliant immediate results that follow the extensive operation. Case 1. A miner, æt. 20, six months before operation was struck on the left shoulder while working in a pit. On admission to hospital there was a prominent swelling in the deltoid region, and marked wasting of the scapular muscles and the biceps. The movements of the shoulder joint were limited, and there was some grating of the articular surfaces. The limb and shoulder girdle were removed on August 8th, 1901. On dissection the tumour was found to have taken origin from the periosteum of the upper end of the humerus. It had involved the shoulder joint, which was full of blood, and had spread to the substance of the scapular muscles, especially the infraspinatus and teres minor. The growth was a mixed celled sarcoma. The patient made an excellent recovery, and remained perfectly well for the greater part of two years. Soon after that the patient complained of pain in the left thigh and leg, and a tumour rapidly formed in Scarpa's triangle. On admission to hospital the disease had already made such rapid progress that radical operation was out of the question. The patient died on May 31st, 1904, a little less than three years from the time the disease first appeared in the shoulder. Case 2. A girl, æt. 14 years, had suffered from pain in the left shoulder for three months. About a month before admission to hospital on February 27th, 1907, a swelling had been noticed, which had increased rapidly. On 3rd March, 1907, the operation was carried out according to Kocher's description, except that the inner half of the clavicle was evulsed from the epiphyseal junction. The tumour was found to be a chondro-sarcoma opening from the upper end of the humerus. For two or three days after the operation the patient was bright and well. Then she developed a troublesome cough, and died on March 27th with malignant disease of the pleura. S.

General Miliary Tuberculosis Diagnosed by Choroidal Tubercle.—Cargill and Mayor (*Trans. Ophthal. Soc.*, 1906) record an interesting case in which the finding of tubercle of the choroid in one eye and a neuroretinitis in the other solved the diagnosis between typhoid fever and general miliary tuberculosis. For six weeks before admission the patient, æt. 21, had been unwell, and for a month had been confined to bed with headache, feverishness and constipation. On admission (Dec. 11th, 1905) he had the "typhoid appearance," temperature 100.6°, pulse 100, respirations 24. No physical signs in lungs, heart, or abdominal organs. No spots. Widal's reaction was negative. Opsonic index for t.b. was 1. No tubercle bacilli were found in the sputum or blood. After admission the temperature varied from 98° to 103°. On December 18th, 1905, the eyes were examined ophthalmoscopically, and choroidal tubercles were seen in one eye and neuroretinitis in the other. Three days before death, on February 20th, 1906, tubercle bacilli were found in small numbers in the sputum for the first time. An autopsy revealed general miliary tuberculosis, the tubercles being found in the meninges along the arteries, over the surface of the liver, pancreas, kidneys, and suprarenals. The lungs were thickly studded with large and small foci. Although general tuberculosis was the most likely diagnosis in this case, the ophthalmoscope afforded nine weeks before death the only physical signs which gave any certainty. The detection of choroidal tubercle is, of course, most helpful in diagnosing the general condition, but it is evidently rare, as Osler says he has "never known a diagnosis made on their presence alone." M.

Children's Sanatorium.

To aid the Children's Sanatorium for the Treatment of Consumption, Holt, Norfolk, an exhibition of pictures and calendars, organised by Miss K. M. Wyatt, whose father is hon. secretary to the institution, and a number of friends, was held on Saturday in the rooms of the Royal Female School of Art, Queen Square. Pending the collection of funds with which to provide permanent accommodation, temporary buildings have been erected at Holt, and a number of cases have already been treated and discharged as "apparently cured." These temporary premises are large enough to receive 15 children, but owing to lack of funds, only 11 cases at a time have been dealt with. To erect the permanent building at present contemplated about £5,000 is required—the site has already been purchased—and of this sum £1,000 is in hand. The Holt Sanatorium was the first, and until recently the only, establishment for the treatment of consumptive children. The exhibitors on Saturday included Mary Countess of Ilchester, Lady Maxwell-Lyte, Miss Gloagh, Miss E. R. Stone, Miss Woodward, and Miss K. M. Wyatt. All the work shown, which included some embroidered fancy articles by Miss Thomas, was for sale, and a sum of over £40 was realised.

Owing to the prevalence of measles, all the infants' schools in Chester have been closed.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

NESCIS.—We have frequently suggested that medical men should adopt the practice of asking for half the confinement fee at the time the engagement is booked. It is not unusual, and is perfectly legitimate. The contract, of course, is equally binding on both sides in such an event, but the obligation is thus assured. The circumstances are annoying, but if you put the patient in the County Court you might quite well lose the case, as you were absent when wanted, and another practitioner was so obviously needed.

FACIES.—Freckles may be treated—if necessary—by drugs that cause exfoliation of the epidermis. A good application is a 1 per cent. solution of perchloride of mercury in alcohol; it should be continued from day to day till the required irritation is produced; 50 per cent. resorcin in zinc paste (Unna) is also useful, but would require the patient to remain indoors.

A DISCLAIMER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I was lately consulted about his eyes by the editor of a provincial newspaper. On his return home, being evidently unacquainted with the rules of the medical profession, he inserted in his paper a paragraph praising my skill as an oculist. I wish to say that the paragraph in question was written and inserted entirely without my knowledge, consent or approbation.

Yours faithfully,
SEAGHAN P. MACENRI.
(JOHN P. HENRY.)

32, Lower Leeson Street, Dublin,
December 8th, 1907.

AQUA DEST.—The name Still's disease is applied to a condition allied to the rheumatoid anthritis (so-called) of young people. Still's disease is a disease of children, and is accompanied by enlargement of the spleen and lymphatic glands.

DR. E. C. T. (Hampstead).—We greatly regret that the insertion of a news paragraph should have given colour to any suspicion that we approve of the treatment in question. We have dealt with it several times in the MEDICAL PRESS AND CIRCULAR, and thought our readers were well acquainted with our views. Although there are unfortunately well meaning philanthropists connected with it, there is an "inventor" in the background who is frankly interested in the sale of the remedy.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, DECEMBER 11TH.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5.30 p.m.: Paper:—Dr. Edgecombe (Harrogate): Blood Pressure in Spa Practice.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. T. P. Legg: Clinique. (Surgical.) 5.15 p.m.: Lecture: Dr. L. Guthrie: Precocious Development.

THURSDAY, DECEMBER 12TH.

ROYAL SOCIETY OF MEDICINE (OBSTETRICAL AND GYNÆCOLOGICAL SECTION) (20 Hanover Square, W.).—7.45 p.m.: Specimens will be shown by Dr. C. H. Roberts, Dr. P. Horrocks, Dr. J. Oliver, Dr. H. T. Hicks, and Dr. Lewers. Paper:—Dr. W. E. Fothergill: The Supports of the Pelvic Viscera, a Review of some Recent Contributions to Pelvic Anatomy with a Clinical Introduction.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—Papers:—Mr. L. Paton: The Diagnosis and Treatment of Some Forms of Simple Conjunctivitis.—Mr. W. F. Fedden: Congenital Talipes.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Card Cases: Mr. R. J. Smyth, Mr. S. Mayou, etc. 8.30 p.m.: Papers:—Mr. S. Snell and Mr. E. Nettleship.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques:—Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4 30 p.m.: Lecture:—Dr. A. G. Auld: Varieties of Cough, their Diagnosis and Treatment.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Fungous Diseases of the Hair: III., Favus; IV., Leptothrix.

HOSPITAL FOR SICK CHILDREN (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. Fairbank: Congenital Dislocation of the Hip and its Treatment.

FRIDAY, DECEMBER 13TH.

ROYAL SOCIETY OF MEDICINE (CLINICAL SECTION) (20 Hanover Square, W.).—8.30 p.m.: Exhibition of Cases by Dr. E. Reid, Prof. W. Osler, Mr. T. H. Openshaw, Dr. F. P. Weber, Dr. W. E. Wynter, Dr. W. Pasteur, and Dr. F. J. Poynton. The patients will be in attendance at 8 p.m.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m.: Shaw Lecture:—Prof. T. Oliver: Industrial Poisons—Lead and Phosphorus, with Special Reference to the Manufacture of Lucifer Matches.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5 p.m.: Special Meeting. Discussion on Inherited Syphilis (opened by Mr. C. Lucas). Followed by Dr. Adamson, Dr. L. Guthrie, Dr. G. Carpenter, Mr. G. Pernet, Mr. S. Stephenson, Mr. A. H. Tubby, and others.

TUESDAY, DECEMBER 17TH.

THE MEDICO-LEGAL SOCIETY.—THE ROYAL ASIATIC SOCIETY (22 Albemarle Street, W.).—8.15 p.m.: President, the Hon. Mr. Justice Walton: 1. Narration of Cases and Exhibits of Medico-Legal Interest; 2. "The Radical Cure—Certification of Inebriates": T. Claye Shaw, M.D.

ROYAL SOCIETY OF MEDICINE (THERAPEUTICAL AND PHARMACOLOGICAL SECTION) (Apothecaries' Hall, Blackfriars, E.C.).—4.30 p.m.: Dr. James McKenzie: The Action of Digitalis on the Human Heart.—Dr. William Soper: Reminiscences of an Apprentice Fifty Years Ago.

Appointments.

CROSSFIELD, H. V., M.B., C.M.Glasg., Clinical Assistant to the Chelsea Hospital for Women.

GREEN, PHILIP, M.D., M.R.C.S., L.R.C.P., Clinical Assistant to the Chelsea Hospital for Women.

HENRY, F., M.B., Ch.B.Glasg., Medical Superintendent of the Highfield Infirmary, Liverpool.

LEGGETT, WILLIAM, M.B., Ch.B., B.A.O.Dub., Senior Assistant Physician at Montrose Royal Asylum.

MURRAY, JOHN, M.B., B.Ch.Dub., F.R.C.S.Eng., Surgeon to the Middlesex Hospital.

POLLARD, ARTHUR HAIG, L.R.C.P., M.R.C.S., House Physician to the Cheltenham General Hospital.

STUART, EFFIE GORDON, M.B.Edin., Assistant Resident Medical Officer at the Sheffield Union Infirmary.

TAYLOR, GORDON, M.B., M.S.Lond., F.R.C.S.Eng., Assistant Surgeon to the Middlesex Hospital.

Vacancies.

Birmingham City Asylum.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Suffolk District Asylum, Melton.—Second Assistant Medical Officer. Salary, £160 per annum, with board, furnished apartments, attendance, and laundry. Applications to the Medical Superintendent.

Bristol General Hospital.—Senior House Surgeon. Salary, £120 per annum, with board, residence, etc. Applications to the Secretary, W. Thwaites.

Stockport County Borough.—Medical Officer of Health. Salary, £450 per annum. Applications to Robert Hyde, Town Clerk, Town Clerk's Office, Stockport.

Leeds City.—Assistant Medical Officer of Health and Chief Inspector of Nuisances. Salary, £300 per annum. Applications to Robert E. Fox, Town Clerk, Leeds.

Great Northern Central Hospital, Holloway Road, N.—Pathologist and Curator. Salary, £100 per annum. Applications to L. H. Glenton-Kerr, Secretary. (See Advert.)

Births.

CUTCLIFFE.—On Dec. 6th, at Court Green, North Tawton, Devon, the wife of Montagu Cutcliffe, L.R.C.P., M.R.C.S., of a daughter.

KINGDON.—On Dec. 5th, at Nelson Street, King's Lynn, the wife of J. Renorden Kingdon, M.R.C.S., L.R.C.P., of a daughter.

SAWYER.—On Dec. 5th, at 14, Farquhar Road, Edgbaston, Birmingham, the wife of James E. H. Sawyer, M.A., M.D., of a daughter.

Marriages.

HILL—BARKER.—On Dec. 5th, at the Parish Church of Llanfor, Merioneth, Charles Alexander Hill, M.A., M.B., of 13, Rodney Street, Liverpool, to Ethel Constance, third daughter of the late Richard Barker, of Huyton.

VERLEY—NORFOLK.—On Nov. 16th, at the Parish Church, Halfway Tree, Jamaica, Reginald Charles Verley, M.B., Ch.B., M.R.C.S., L.R.C.P., B.Sc.(Edin.), son of the late James L. Verley, of Jamaica, to Helen, fourth daughter of the late Robert Norfolk, J.P.

Deaths.

DRYSDALE.—On Dec. 2nd, at 28, Carson Road, West Dulwich, Charles Robert Drysdale, M.D., M.R.C.P., F.R.C.S. Consulting Physician to the Metropolitan Hospital, aged 78.

GRAHAM.—On Dec. 5th, at 14, Old Cavendish Street, London, George Herbert Graham, M.D., late of Storrington.

JEAFFRESON.—On Dec. 1st, at Rouxville, Orange River Colony, South Africa, Alfred Ernest Jeaffreson, M.B., B.C.Cambridge, M.R.C.S., L.R.C.P.London, formerly Assistant Physician of Bridewell Royal Hospital.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, DEC. 18, 1907. No. 25.

NOTES AND COMMENTS.

The "Standard" and Medical Butchery.

AN advertisement which appeared in the *Standard* has been sent to us. It is headed, "Appendicitis and Medical Butchery," and proceeds on this wise :—"Why be slain by costly operations when a certain cure can be obtained by natural means? A few years ago no such disease could be found in the medical vocabulary, and there is a VERY GREAT USE FOR THE APPENDIX the ignorance of which is a disgrace to the medical profession." After this opening we are not surprised to find a lot of mystic bunkum about "magnetic auras," "vital force," "nervous breakdown," and so on, and a statement that "all this can be stopped by scientific magnetic force from a gifted healer." This endowed individual is "Professor" W. H. Edwards, "who has been publicly tested in every variety of disease," "and who positively undertakes to relieve every kind of internal inflammation, often mis-called 'appendicitis,' without operations of the surgeon's knife." After reflection, we have little hesitation in saying that we consider this advertisement the most offensive concoction that we remember to have read, and to label it as a disgrace to the *Standard*, or any other paper claiming respectability. Under the old management it would have been impossible for such an impudent libel on the medical profession or any other body of men to find its way into the advertisement columns of the *Standard*, but apparently times have changed, and, with them, manners.

Quantum Mutatus.

WITH "Professor" Edwards we are not much concerned. Gentlemen of his kidney are sufficiently numerous, and more than sufficiently offensive to medical practitioners who abide by a code of honour and rules of decency. But that a responsible journal of the type of the *Standard* can so far forget what is due to any recognised profession as to print in large letters such an abominable insult as "Appendicitis and Medical Butchery" is a more serious matter. It shows, we think, a very rapid and abysmal fall from what was till recently considered becoming and decent, and we would advise medical men who read journals which degrade themselves in this way to write to the editors by way of protest. In the absence of decided action or expression of feeling these insults have gone from bad to worse, till "Medical Butchery," in speaking of ordinary surgical proceedings, is not considered too outrageous for a journal appealing to the better educated classes to publish in the ordinary way.

The "Daily News" and Student Disturbances.

PAPERS hostile to medicine and national science, such as the *Daily News* and the *Star*, had another innings last week through the renewed "Brown Dog" disturbances. The *Daily News* is frankly delighted. "We welcome these demonstrations," it says, "because they are favourable to the anti-vivisectionist cause." As in the same article it is asserted that some of the demonstrators were drunk—a suggestion we have not seen put forward elsewhere—the joy that animates a nominally temperance paper such as the *Daily News* would be hard to understand, if we did not realise that no weapon is too tarnished and no blow too foul if thereby medical men and science are to be hit. Student rows are common in all University towns, whether in Scotland, Ireland, Wales, Oxford, or Cambridge, and people accustomed to the presence of students recognise them to be irresponsible creatures, who are not always wise, not always rational, and, alas! not always possessed of discriminating taste. The police in University towns, as a rule, understand student-nature, and practice the art of restraint with good sense and good temper; the London police have so little experience of student manifestations that they regard them much as the Russian police do demonstrations at the universities in that bureaucratic country. It is utterly irrational, of course, for students at the same time to protest against an offensive monument and to turn it into a joke; the phenomenon can only be explained on the well-known principle of "turning to mirth all things on earth, as only boyhood can."

Philosophy of Strikes.

BUT if a mob of strikers, labouring under a sense of injustice, break the windows of Government offices or smash the railings in Hyde Park, the statesman, while condemning the excesses, seeks for the cause of the trouble, and endeavours to adjust it. Breaking windows, smashing railings, and parading effigies of dogs, are stupid and reprehensible methods, but they generally indicate a grievance, and they do not necessarily indicate the offenders to be possessed of a larger dose of original sin than their fellows who have not a grievance. There are many gentlemen of the highest respectability holding exalted positions in the State who, in their younger days, have been guilty of blatant excesses. Every man of middle-age can point out a dozen well within his own knowledge. So that to found any argument on the present regrettable street-rows is not only unfair but plainly the outcome of spite looking for a reason to justify its existence. This is all the more evident when it is remembered that the very papers that are now using the incidents under notice for their own purposes, were a few months ago doing all they could to mollify the disgust excited in the public mind by the unwomanly tactics of the "Suffragettes," and only retreated from that attitude when they found they had burned their fingers and that the demonstrations of these Amazons were directed personally at the leaders of their own political party. We do not remember these journals welcoming the demonstrations as being fatal to the cause of women's suffrage, or as showing what sort of order in the country would be the probable result of the success of the movement.

Snobbery and Abuse.

But the vapourings of the *Daily News* are outdone by the lucubrations of the *Star*. This journal is, perhaps, the most persistent reviler of medicine, and what it is pleased to call the "medical priesthood," that we have to contend with. As it is very ably edited and has a large circulation among the working-classes, the injury it does to the poor in the way of sowing distrust of medical advice is doubtless very great. Considering that its advertisement columns are filled with the most offensive announcements of quack medicines, and its revenue is therefore largely dependent on the money extracted from the poor by their sale, any pretence of serving the public interest by denouncing medical methods is calculated to strike an observer as the most unctuous hypocrisy. The student disturbances are a god-send to the *Star*. It begins a leader on them by sympathising with the police, a force which it usually delights in denouncing, and which a non-medical witness described in this particular instance as behaving "like a lot of savages." It then toadies to the older universities by congratulating them on their refusal to join the "medical larrikins" in "the riot," and proceeds sarcastically to inquire "at what stage in his evolution does the medical hooligan become the humane scientist?" Finally, it winds up its article with a quotation, adapted from something Robert Louis Stevenson wrote about the art students of Paris, and applies it "to the cads of medicine" Surely gutter journalism, under the transparent guise of righteous indignation, here reaches its nadir.

"Un-English, libellous, and provocative."

For every reason we are glad to think that this painful chapter of incidents is likely soon to be closed. A member of the Battersea Borough Council, Mr. Runeckles, has given notice that he will move at the next meeting of that body that, "as a matter of good sense and good taste, the un-English, libellous, and provocative inscription of 'Little Brown Dog Memorial' be removed." We sincerely hope that the Borough Council of Battersea will accept the motion. As we have said before, the inscription is not only calculated but is obviously designed to stir up ill-feeling, and on every ground such a cause of offence should be removed. Mr. Runeckles is taking a dignified and statesmanlike step, and we trust the Council will dismiss from their minds all prejudice and prepossession and accept the motion.

LEADING ARTICLE.

DABBLING WITH HUMAN AILMENTS.

The coroners of the United Kingdom have undoubtedly a great power in their hands as regards the suppression of the evils of patent medicines and unqualified medical practice. To their honour be it said that the matter has engaged their attention both collectively in their society discussions, and individually in many conspicuous instances. For the full position of this tragedy is to be found in the dead bodies of the patent medicine vendors' victims who are thus brought before the public as grim evidence of the cupidity of their fellow-men. The single article of so-called teething powders is answerable every year for the deaths of a great number of infants. Yet the trade goes merrily on, and the proprietors of these poisonous and scientifically worthless nostrums amass large sums of money out of the credulity of the poorer classes. Then there is the noxious class known as herbalists, whose names are not infrequently connected with illegal operations. Two recent cases of public censure of such persons by coroners for quackery may be cited. In the first, Mr. S. Brighouse, County Coroner, held an inquest upon the infant son of a collier named Cawley, living in Ashton-in-Makerfield. The child, previously healthy, was taken ill when about ten months old. The mother began treatment with a "Fenning's tooth powder," an unknown quantity, and a dose of castor oil. Next morning the unfortunate child appeared a little better and she gave another dose of castor oil, but the day after she went to Mr. Hill, a herbalist, of Ashton, and obtained a bottle of mixture and a powder. Next day the child died before the arrival of a medical man, who was not summoned until that stage of the proceedings. In evidence it was shown that Mrs. Hill examined the child, and sixpence was paid for advice, medicine, and powders. As a matter of fact, the child died from bronchial pneumonia; no attempt had been made to take the child's temperature, so that the data for a proper diagnosis were defective. It appeared that the Hills had dosed the unhappy infant with syrup of rhubarb and antifebrin. With regard to the latter drug, it is not necessary to remind medical readers of the risks attending the use of so powerful a drug. Of the many deaths that have followed its use some at least have been amongst young persons, and its administration to infants requires the exercise of the highest and most responsible medical skill available. The fact that ignorant persons can openly avow in a public Court that they have prescribed antifebrin shows the impotence of the Medical Acts to protect the safety of our countrymen against the machinations of unqualified medical practice. The woman herbalist had the brazen audacity to state she had used antifebrin for the past twelve years. In accordance with the wish of the jury, Mr. Coroner Brighouse gave this precious pair a sound rating for "dabbling" with human ailments about which they knew nothing. There the matter ends, but surely the police, had they a mind to it, could prosecute this Hill and his wife for obtaining money under false pretences. The attention of Parliament might well be called to this incident by any Member who is sufficiently interested in the safety of the community, especially of its rising generation. The second case to which we would refer briefly was divulged at Brighton on October 10th. The Coroner, Mr. J. E. Bush, held an enquiry into the death of a young woman who had died shortly after being discharged from the Sussex County Hospital, where she had been under treatment for leukæmia. Her case was regarded as hopeless, and her friends called in a local herbalist of the name of Stokes. This man visited the poor girl at home, and gave her medicine "for the kidneys, liver, and nerves," in spite of which treatment he admitted having been surprised at her sudden collapse and death. He claimed, however, that he had kept her alive for eighteen days. This man had the impudence to boast he had been "practising" for over fifty years, and had cured cases given up by doctors, and even doctors themselves. The

Coroner wound up with the usual formal censure of the herbalist, at the wish of the jury. Such practices, it is needless to remark, will need more drastic handling than the mere delivery of a public remonstrance. "Hard words break no bones" is essentially a motto for quacks. It is to be hoped that the movement recently set on foot by the General Medical Council will result in some short and sharp legislation to rid society of such cruel harpies and parasites as herbalists and other quacks of the same kidney.

CURRENT TOPICS.

Suggested Royal Commission on Scarlet Fever.

It may be still remembered that three years ago The Medical Press and Circular took up strongly the position that a Royal Commission, or other authoritative inquiring body, should be appointed to investigate the relation of isolation hospitals to the spread of scarlet fever. By means of papers contributed by medical men having special knowledge of the position, and by editorials, the matter was placed before the public, and although some support was received, the matter, on the whole, was not warmly accepted. We realised that the isolation hospital was such a convenience in many ways that, as regards scarlet fever, any steps that seemed to infringe its prerogative would be certain to meet with opposition; but we held then, and hold as strongly to-day, that the problem is a great and puzzling one calling for a large and independent investigation, considering the magnitude of the sums invested in maintaining scarlet fever patients and the poverty of the results achieved. We have returned to the subject over and over again, but the fruit, though long in ripening, has yet to be gathered. That step, however, is appreciably nearer. On December 5th, Professor W. R. Smith submitted a motion to the Metropolitan Asylums Board to the effect that in view of the continued prevalence of scarlet fever, notwithstanding the extensive isolation accommodation which has been provided, the Local Government Board be asked to cause an inquiry to be instituted into the cause of the disease, and whether any, and if so, what, further means can be adopted for its prevention. Professor Smith said that medical science had not yet discovered the cause of the disease, and by an inquiry the burden on the ratepayers might be reduced. Personally, he thought the matter ought to be submitted to a Royal Commission. That motion was adopted unanimously.

The Extinction of the Eskimos.

One of the ironies of so-called civilisation is the way in which contact with its vices secures the extermination of primitive tribes. The case of the rapidly disappearing Eskimos is pathetic in the extreme, and it is pleasing to record that one of their strongest friends and champions is an English medical man, Dr. Grenfell. In former times the natives of the frozen country of Labrador wrung a livelihood out of their barren surroundings by the aid of native weapons and by dint of hard and adventurous living. Now, as a matter of fact, they are being rapidly exterminated from the face of the earth by the continued ravages of hunger and disease. Armed with modern weapons of civilisation, they have killed off the herds of musk ox merely for the sake of their skins. In that way they have destroyed their main source of food-supply. Then, again, they are being decimated by syphilis, introduced by the crews of the whaling ships. Whole tribes are said to have been destroyed, in some instances under terrible circumstances. It seems clear that the countries that send the whalers are morally responsible for this result. Why should not the wanton spread of syphilis be a punishable crime? Canada has forbidden the export of musk ox skins, so that the natives should not exterminate them for the sake of the hides. It would be well if the legislation of that Dominion would deal with the evil of syphilis in an equally prompt and decisive manner.

Slums and Coroners.

The Truro Coroner has taken a step that bids fair to have somewhat far-reaching consequences. In a case under investigation in which death was attributed to bad surroundings, the Coroner called in some prominent members of the sanitary administration of the town, and after requesting them to inspect the premises concerned, called them as witnesses. It would be hard to imagine a more dramatic and effectual way of bringing home to those responsible for the local sanitary welfare a conviction of their own shortcomings. Were object-lessons of this sort to become general, we venture to predict that the terrible evil inflicted upon the community by the owners of slums would be speedily abated. For one thing, it is obvious that evidence of the kind would have an inestimable value in tenants' actions for damages for injury to health and life through insanitary premises, of which several have been successfully conducted in recent years. As irremovable and independent Crown officials, the coroners are almost the only persons able to fight such strongly-vested private interests as those interested in slum property and patent medicines. The owners of bad houses have long ago recognised the advantage of being strongly represented on local governing bodies. It is not likely, however, that they would survive many pillories in the Coroner's court. It is to be hoped that the example of the Truro Coroner may be followed by his brethren throughout the United Kingdom.

Indian Hospital Assistants' Journal.

We have received a copy of a new medical journal which gives us peculiar pleasure, namely, the *All-India Hospital Assistants' Journal.* The hospital assistants have formed an Association which, in their own words, "aims at the scientific, moral, and material progress of our class," and the journal is the organ through which the members scattered over the vast peninsula are kept in touch with one another and instructed. That the hospital assistants desire improvement and are capable of forming such an Association and editing such a journal must give great satisfaction to those who sympathise with the native aspirations in India, and wish to see a happy, well-governed, and prosperous people in that Empire where England has such vast responsibilities. The surest path of progress is through the practice of self-culture and the assumption of responsibility, and we warmly congratulate the hospital assistants on their enterprise, which, if wisely carried out, will be a source of help to the officers of the Indian Medical Service under whom they serve, just as the organisation of professions and trades at home is of assistance both to the members and those with whom they come into contact. The number of the journal before us speaks with appreciation of the Indian Medical Service, and the official approval of the movement is testified to by the patronage of highly-placed officers. In connection with the movement against quackery which THE MEDICAL PRESS AND CIRCULAR is constantly keeping alive, it is interesting to us to read in a paper by Mr. P. S. Ramchandrier, of Ahmedabad, the following passage:—"I do not like to omit what I have to say about your duty to put down the charlatan in the stations you will be in charge. This is most rife in India. It is wonder to me how this benign Government which takes superb care to prevent any ordinary man not to practice law without professional course in a recognised institution, allows scot-free men veneered with sanctimonious theories of medicine to practice their arts on slaughtering the ignorant and poor agriculturists. What is not done by the ruling power, people like us can to a certain extent do for ourselves." An autocratic Government like that of India ought to grapple with the question soon and strongly; it is not beset with the difficulties met with in this country. It strikes the British reader curiously to read of a concession granted to the assistants. "Hospital assistants are not required to fire a revolver course" runs a new regulation. Perhaps the quacks will be glad too. But, revolvers or no revolvers, we stretch out the hand of welcome to our native fellow-subjects.

Infantile Mortality at Huddersfield.

THE endeavours of the municipal authorities of the borough of Huddersfield to cope with the evil of infant mortality have within the past year or two attracted much public interest. By virtue of a special Act which came into operation exactly a year ago, the Corporation has had, during the past twelve months, special powers it did not previously possess, and it is interesting to note the effect of the working of this Act. Under it all births have to be notified to the health authorities within forty-eight hours, and it appears that 94 per cent. of all the births have actually been so notified. All the exertions of the health authorities are in the definite direction of helping the mother to nurse her child in her own home. On the notification of each birth, a medical woman, assistant to the medical officer of health, calls at the address given, and if advice as to infant management is needed, she gives it. Ladies, who act as honorary visitors, give their help, and, where necessary, continue to supervise the care of the infant. No dole of any kind is given, either by the visitors or by the municipal authorities. The results have been better than anyone could have hoped. The infant mortality rate for the first nine months of the year has been 85, whereas for the corresponding period of last year it was 138, and the mean for ten years was 135. Comparing the mortality in Huddersfield with that in other towns a great difference appears. In the third quarter of the year the infant mortality rate in the seventy-six towns of the Registrar-General's list was 110; that of Huddersfield was 62. We congratulate the municipal authorities on their magnificent success, and we wish that other towns would follow their example. It is stated that the pecuniary expenditure for this saving of infant life has not exceeded £400 a year!

Appendicitis and Plum-pudding.

WHAT is the relation of plum-pudding to appendicitis? Lest the question should shroud the Christmas season with an appalling gloom, we hasten to say that there is no appendicitis in plum-pudding. The grotesque theory still propounded by some kill-joys that pips in the pudding cause appendicitis is a hoary turnip-headed scarecrow. So far from upsetting the digestion, there can be nothing finer, more digestible, nourishing, toothsome, and sustaining than good, wholesome English plum-pudding made from a sound recipe. Let mothers take this kindly medical advice to heart. It is not the plum-pudding that hurts the child, but rather the stuffing with fruit and comfits and lollipops and candies and other of the rich cates that cluster round the merry Yuletide. Let a healthy youngster abstain from these things between meals, and let the meals be plain, then there will be no need to shun the plum-pudding on Christmas Day. For it is clear to the plain man as to the 'pothecary that plum-pudding hath its scientific as well as its grossly material and fleshy aspects. It is from our love and veneration of this finest of old English dishes that we would point out to our fellow-countrymen of all ages, all sexes, and all temperaments, how to enjoy to the utmost the brief but all-conquering season of its advent. We lay it down as a law of the Medes and Persians that no plum-pudding has half the heavenly savour of that served up in Christmas week decked with a sprig of berried holly and wreathed in lambent flame. So mote it be to all of us!

The British Medical Association and its Charter.

WE have before now commented on the question of the British Medical Association petitioning for a Royal Charter, and we have advised the members to exert due caution before committing themselves. For several months a warm debate on the subject has been in progress, and at the present time a referendum is being taken to settle the question. The official journal, which is working hard for the Charter, in this week's issue makes a quotation from the legal adviser of the Association which may or may not help towards that object. Mr. Beaufort Palmer says that if the Association were under a charter instead of being, as at present, governed by the Companies Acts, it "would be freed for all practical purposes from the trammelling rules of the Courts in regard to what is and what is not *ultra vires*." In other words, the property and interests of the members would not be so securely safeguarded as at present. This might be a very serious matter, as it would be difficult to rectify an unwise action. The members will be wise to watch any further developments which would emancipate the governing body "from the trammelling rules of the Courts." Incidentally, we may notice that the debate on the question has brought about a curious position in the Association, in that the Council and the representative meeting have found themselves in disagreement, and the duel system of government of the Association established a few years ago has not worked well.

The Reform of the Irish Poor-Law.

The Chief Secretary for Ireland has during the past week informed an influential deputation which waited upon him that the Irish Government were drafting a measure dealing with Poor-law reform, that it had first place on their list, and that it would be proceeded with as soon as ever time could be found for it. Further, he stated that the recent report of the Viceregal Commission would furnish a basis for the proposed legislation. As our readers know, one of the most important recommendations made by this Commission was the conversion of the existing Poor-law Medical Service into a State Medical Service. This proposal was cordially supported by the Irish medical Colleges, the Royal Irish Academy of Medicine, the Irish Medical Association, and other kindred organisations. The necessity for some such step has been fully recognised, and almost its only opponents are the various local boards which would lose opportunities of patronage. Human nature being what it is, such opposition is only natural, and surely it ought not to be allowed to weigh against a measure so urgently demanded in the interests of the Irish poor. Mr. Birrell, in his reply to the deputation, referred to the fact that so many of the recommendations of the Commission were contentious. He, however, above all men, should not shrink from what he considers necessary, because he must by this time know that nothing in Ireland which is worth anything is free from contention.

Defaulters under the Midwives Act.

The working of the Midwives Act is now advanced far enough to warrant some sort of conclusion as to its future progress. The "Association for Promoting the Training and Supply of Midwives" is already appealing to the public for a vast sum of money to enable the training of midwives to be conducted on a national scale. Where the matter will end is a subject for speculation, but there appears to be a not altogether remote prospect that eventually medical men will find themselves faced with the competition of an army of pseudo-medical practitioners. At present the fear is more than justified by the terrible roll of indictments against 33 midwives presented last week before the Central Midwives Board. Several women were accused of administering medicines other than a simple aperient without entering the fact upon a register. One woman is stated to have administered a vaginal douche with a syringe previously used to give an enema. A number of cases of drunkenness were on the list. Failure to report puerperal fever occurred in many instances, and often nurses continued attendance on other labours while infected from a puerperal case. Neglect to call in medical men formed a large proportion of offences; in the majority of instances the midwife failed to seek such assistance for puerperal fever; but there were several cases of ruptured permanent or retained placenta in which she apparently considered the advice of a medical man superfluous. It will, of course, be argued by the supporters of the Act, that these cases simply prove the need of special training and of rigid supervision. While that may be admitted it nevertheless seems no less clear that the contentions of the medical men are being amply justified when they asserted that certificated midwives would infallibly regard themselves in many cases as entitled to carry on a sort of hybrid quack medical practice under the ægis of their diploma.

PERSONAL.

Dr. Robert Maguire has been installed as Master of the University of London Lodge of Freemasons.

Dr. John C. S. Rashleigh, of Par Station, Cornwall, have been nominated a Sheriff for that county.

Dr. Thompson. of Feeny, has been placed on the Commission of the Peace for the County of Londonderry.

The award of the Nobel Prize for Medicine has, as anticipated, been made to Dr. Laveran, of the Pasteur Institute.

Dr. James MacLachlan has been re-elected Provost of the Dornoch Town Council for a further period of three years.

It is announced that Lord Cromer has accepted the office of honorary vice-president of the Liverpool School of Tropical Medicine.

On his retirement from the Liverpool Royal Infirmary, Mr. Rushton Parker's students, past and present, are presenting him with his portrait in oils.

Dr. William Berry has been presented with a silver tea service in recognition of his twenty-five years' service as Honorary Secretary to the Wigan Medical Society.

Professor Moritz Schmidt, of Frankfort, who recently was the recipient of the title of "Excellency" in recognition of his services to laryngology, has, we regret to hear, recently died.

The annual dinner in connection with the Medical School of the Birmingham University was held at the Grand Hotel on December 10th. The chair was occupied by Dr. J. W. Russell.

Dr. Charles James Sutherland has been promoted to be a Knight of Grace of the Order of the Hospital of St. John of Jerusalem. A similar distinction has been conferred on Lieut.-Colonel E. J. Hunter.

Dr. Arthur J. Hall, Physician to the Sheffield Royal Infirmary, has been appointed Lecturer on Practical Medicine in the University of Sheffield, rendered vacant by the resignation of Dr. W. Tusting Cocking.

The medical men of Old Withington have presented Dr. Railton with a silver rose bowl on the occasion of his retiring from the office of Medical Officer of Health of the district, which post he had held for 35 years.

Dr. Alexander James was entertained at dinner by numerous medical friends on the occasion of his retirement from active service as Physician to the Edinburgh Royal Infirmary. Dr. Underhill, President of the Royal College of Physicians, occupied the chair.

With the advent of the New Year Dr. A. Wynter Blyth will cease to hold the post of Medical Officer of Health of Marylebone, still retaining, however, that of local Public Analyst. His successor in the medical officership is Dr. Meredith Young, Medical Officer of Stockport.

The Right Hon. the Earl of Meath, K.P., P.C., H.M.L., Co. and City of Dublin, with the approval of his Excellency the Lord-Lieutenant of Ireland, has been pleased to appoint Mr. William Askin Shea, of "Elmville," 5, Garville Avenue, Rathgar, and 28, Westland Row, to be a Deputy-Lieutenant of the City of Dublin, in place of Charles E. Martin, Esq., D.L., deceased. Commission dated December 7th, 1907. Mr. Shea is a J.P. of the City of Dublin and Vice-Chairman of the South Dublin Poor Law Board of Guardians and Registrar of the Incorporated Dental Hospital, Dublin.

A CLINICAL LECTURE
ON
FRACTURES AT THE WRIST. (a)

By D'ARCY POWER, F.R.C.S.Eng.,

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[SPECIALLY REPORTED FOR THIS JOURNAL.]

GENTLEMEN,—I propose to talk to you to-day about fractures at the wrist, illustrating my remarks by skiagraphs, for which I am indebted to our X-ray department, which is so excellently managed by Dr. Lewis Jones and Dr. Walsham, though I am the more especially indebted to Mr. J. M. Flavelle for the trouble he has taken in selecting from the common stock so splendid a series of illustrative plates. If I had chosen this subject ten years ago I should have spoken of it as "Fractures of the Lower End of the Radius," and when I used to teach you the elements of fractures and dislocations more than twenty years since, we merely called it "Colles' fracture."

By taking advantage of successive advances in physics and surgery we have achieved very satisfactory results in diagnosis, and where we used to employ a specific name we are now obliged to reconsider the nomenclature and sub-divide the injuries at the lower end of the wrist into a variety of groups, which may be thus tabulated:—

Radius.	Separated lower epiphysis.		
	Unimpacted fracture.		
	Impacted fracture.	Simple.	Colles' fracture.
		Lower fragment comminuted.	
	Oblique fracture through articular end without comminution.		
	Styloid process detached.		
Ulna.	Separated lower epiphysis.		
	Fracture of shaft in lower third.		
	Styloid process detached.		
Scaphoid.	Simple fracture.		
	Fracture with dislocation of one fragment.		
Radius and Ulna.	Transverse fracture.		
	Colles' fracture with styloid process of ulna torn off.		
Radius and Scaphoid.	Colles' fracture with fractured scaphoid.		
Ulna and Scaphoid.	Fracture of Scaphoid with tearing off of styloid process of ulna.		

I need hardly call to your notice the clinical features which are common to a broken wrist. You all know the picture which you see so often in the surgery. A patient, rather pale and shaking, who holds one wrist tightly grasped against his chest by the other, and pushes open the door with his shoulder. He says that he has just fallen and sprained his hand. It is very painful, and quite useless. Examination shows that the wrist is deformed and bent to the radial side, so as to reveal the lower end of the ulna with unnatural clearness. Movements of pronation and supination are impossible, or are made by an awkward twisting of the arm from the shoulder or elbow. Closer examination shows that the deformity is due to a bony swelling in a typical case, the swelling being more marked on the dorsum than on the palmar surface.

Yet, with all these marked signs and symptoms, it is remarkable how long a fracture of the lower end of the radius escaped notice, for it seems to have been looked upon as dislocation of the wrist, a form of injury which is very rare. Abraham Colles was not quite the first to call attention to the true nature of the injury, but he was the first to describe it so simply and accurately as to make it his own, and to render his name one of the household words in surgery. I hold in my hand his original paper. It is dated from St. Stephen's Green, Dublin, 1814. It is less than four pages in length, and it appeared in the *Edinburgh Medical and Surgical Journal* for the year 1814 Vol. X., p. 182). The paper begins:—"The injury to which I wish to direct the attention of surgeons has not, as far as I know, been described by any author. Indeed, the form of the carpal extremity of the radius would rather incline us to question its being liable to fracture. The absence of crepitus and other common symptoms of fracture, together with the swelling which instantly arises in this as in other injuries of the wrist, render the difficulty of ascertaining the real nature of the case very considerable." Colles then describes the clinical signs, and adds a few comments on the prognosis and treatment. It is interesting to notice that a surgeon of such gigantic experience as Sir Astley Cooper was not clear as to the mechanism of the fracture, although he had examined broken wrists post-mortem. Colles' explanation passed current, and without much criticism, until 1842, when Voillemier stated that he believed that impaction was essential in fractures at the lower end of the radius, a conclusion which was criticised adversely by Prof. R. W. Smith in 1847, and was adjudicated upon by Prof. E. H. Bennett in 1879, who found that both writers had been too absolute in their statements.

A.—SIMPLE FRACTURE OF THE LOWER END OF THE RADIUS.

I show you a skiagram of a perfectly simple fracture of the lower end of the radius within a quarter of an inch of the carpus. It shows clearly the mechanism of such an injury. The scaphoid and the semi-lunar bones in the proximal row of the carpus are closely connected with the articular surface of the radius; whilst the cuneiform bone is separated from the lower end of the ulna by the triangular fibro-cartilage. When a patient falls upon his outstretched hand, the whole force of the shock comes upon the lower end of the radius, and it is transmitted rather obliquely because, as the skiagram shows, the axis of the wrist is itself slanting. The pressure, therefore, is exerted upon the outer or styloid-process side of the radius. The skiagraph shows further how weak the lower end of the radius is as compared with the shaft of the bone, for the expanded end of the radius is cancellous tissue, with a thin covering of compact bone, whilst the shaft is compact bone without much cancellous tissue.

The next skiagraph shows a transverse fracture of the lower end of the radius in a patient whose lower epiphysis is not yet united. It shows, too, why such fractures are rare in children, Colles' fracture being essentially a fracture of adult life. In a young person the shock of a fall upon the hand is distributed by two buffers—first, the elasticity of the epiphysis, and, secondly, the intermediary cartilage which lies between the epiphysis and the shaft forming the growing part of the bone. In young persons, therefore, a severe injury is saved to the radius, but may be transmitted further up the arm, causing a backward dislocation at the elbow, or even a broken collar-bone.

B.—IMPACTED FRACTURE OF THE LOWER END OF THE RADIUS.

The next plate shows the condition which we recognise as typical of a Colles' fracture. The radius is broken close to its carpal extremity, and the lower fragment has been penetrated by the upper fragment in such a manner that the upper fragment is driven obliquely into the lower extremity. There is no comminution of the lower fragment; the styloid process of the ulna and the lower end of the ulna are both uninjured. A closer examination of the plate shows that the impaction of the fracture has occurred, so that the upper fragment enters the lower obliquely from above downwards, the lower extremity being driven upwards, backwards and outwards. The impaction, moreover, is not complete, because the cancellous tissue of the lower fragment does not contain both layers of the compact tissue of the upper fragment, and there is clearly inter-penetration. This is seen in the side view of the wrist, and is not shown in the antero-posterior skiagraph. It is well, therefore, to have two views of every broken wrist, one taken with the hand flat and one in profile.

(a) Delivered at St. Bartholomew's Hospital on Wednesday, November 27th, 1907.

C.—COMMINUTED FRACTURE OF THE LOWER END OF THE RADIUS.

When the violence leading to a broken wrist has been considerable, the lower end of the radius may be comminuted, as is shown in this skiagraph. I called attention to this form of fracture so long ago as 1887 (*Trans. Path. Soc.*, Vol. XXXVIII., p. 250), and our museum contains several excellent instances of it. This plate shows the lower fragment split vertically into two pieces, but without much impaction, and with no injury to the ulna. Such an additional injury renders the prognosis more serious, because the carpal joint is involved, and the wrist may easily become stiff unless it be recognised and measures be taken early to counteract its effects.

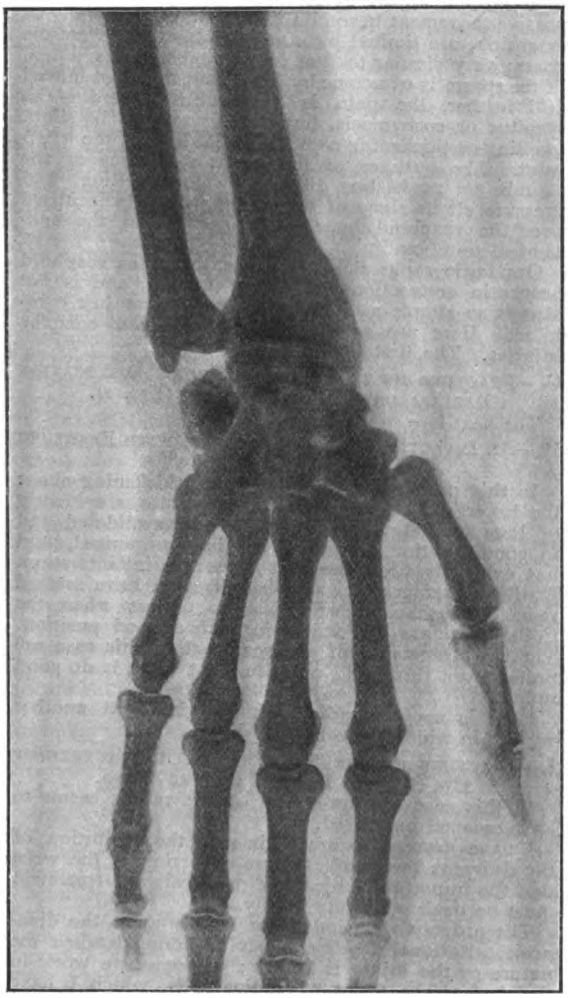

FIG. 1.—SIMPLE FRACTURE OF THE SCAPHOID, WITHOUT DISPLACEMENT OF EITHER FRAGMENT.

These fractures were practically all the forms of broken wrist recognised before the advent of skiagraphy, but, as our scheme shows, several additional forms are now clearly recognised.

D.—OBLIQUE FRACTURE THROUGH THE CARPAL ARTICULAR SURFACE OF THE RADIUS.

The next radiograph shows an entirely different form of fracture. Half the articular surface of the radius is separated from the other half by a line of fracture extending from the scapho-lunar facette obliquely outwards, and ending at some distance above the base of the styloid process. A slighter form of fracture which was probably only recognised as a bad sprain is seen in this radiograph, where the styloid process of the ulna is separated without injury to the articular surface. In neither of these fractures has there been any injury to the ulna.

E.—FRACTURE OF THE STYLOID PROCESS OF THE ULNA.

In these skiagrams the styloid process of the ulna has been torn away, whilst the radius is intact. It is plain that the fracture of the styloid process is not always at the same spot, for in one radiograph it is a mere nodule of bone which has been detached, whilst in these the whole styloid process has been torn off. It appears most probable that such fractures of the styloid process of the ulna have generally been looked upon as bad sprains of the wrist until radiographs showed their true nature.

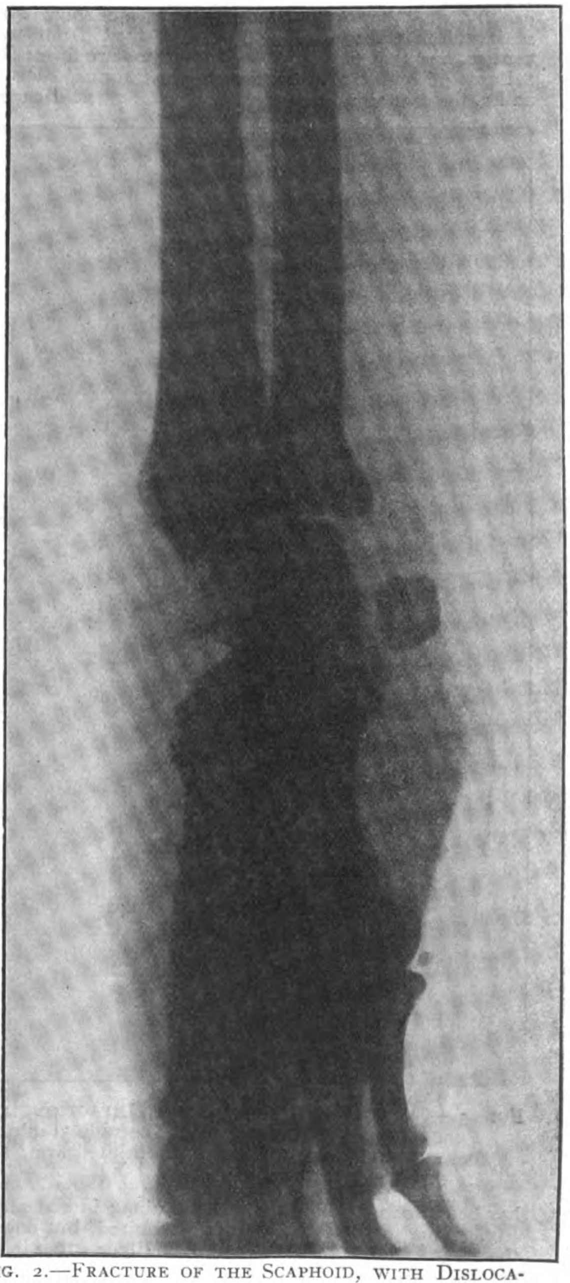

FIG. 2.—FRACTURE OF THE SCAPHOID, WITH DISLOCATION OF ONE FRAGMENT.

F.—FRACTURE OF THE SCAPHOID.

The next group of radiographs shows an interesting series of fractures of the scaphoid, fractures which have hitherto been very little known, but which are evidently not uncommon, for here are several different plates showing similar appearances.

The scaphoid, as you well know, is one of the larger bones of the carpus partially curved upon itself and traversed obliquely by a groove. It is easy to imagine that under pressure from the os magnum and the articular surface of the radius the scaphoid would be broken into two fairly equal fragments, and the figures 1 and 2 which are reproduced from the radiographs I show you prove that this is exactly what happens, although there are some who maintain that the scaphoid is developed from two centres, and that these apparent fractures are in reality failures of ossification. In the simplest forms, Figs. 1 and 3, the scaphoid is merely fractured, and no damage has been done to the radius or the ulna; in one plate, Fig. 2, the scaphoid is not only fractured, but one of the fragments has been displaced bodily, so that it lies on the dorsum of the wrist. This displacement would have been overlooked if the radiographer had omitted to take two pictures of the wrist, one flat, the other in profile, so that here is another instance of the importance of taking more than one view of every fracture.

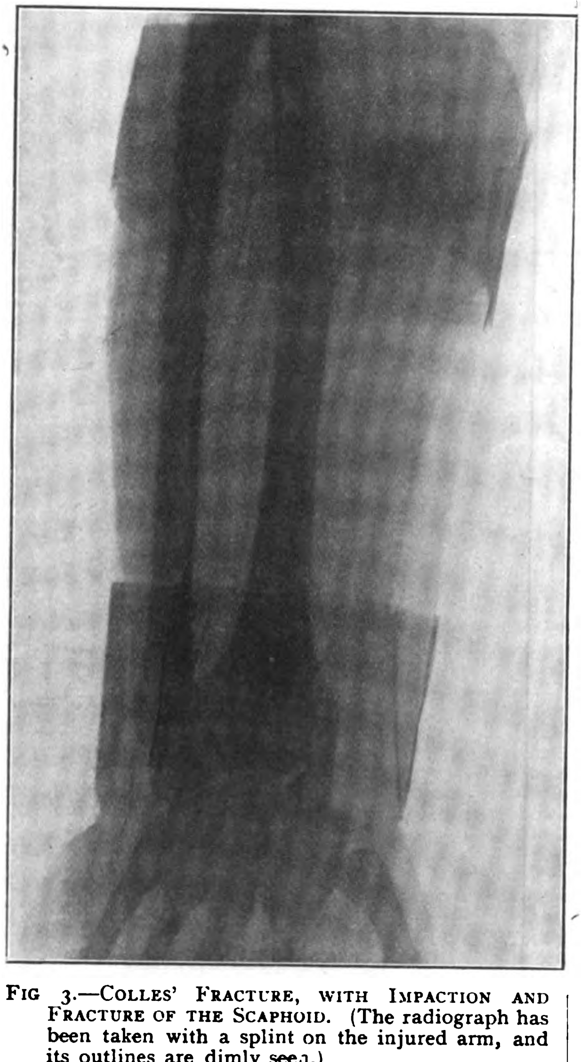

FIG 3.—COLLES' FRACTURE, WITH IMPACTION AND FRACTURE OF THE SCAPHOID. (The radiograph has been taken with a splint on the injured arm, and its outlines are dimly seen.)

Drs. Codman and Chase, of Boston, Mass., have published a most excellent monograph on the diagnosis and treatment of fracture of the carpal scaphoid and dislocation of the semi-lunar bone. It appears in *The Annals of Surgery* for 1905, Vol. XLI., and from their account I take the following passages:—"The patient, usually a male of from twenty-five to thirty-five years of age, has fallen on his extended wrist in the same manner as in the injury which usually causes a Colles' fracture. He has supposed that he has sprained his wrist, and for a few days has suffered severe pain and tenderness, and has been unable to use his hand for ordinary purposes. During a period varying from a few days to a few weeks, according to the hardihood of the individual, he has refrained from using his wrist. Gradually he has been able to take up his work again, but after a certain point the soreness, tenderness, and disability have refused to improve. Eventually he comes to the hospital complaining of pain, tenderness and weakness of the wrist. Examination shows that the fingers have their normal flexibility, but that the active and passive movements of the wrist-joint are limited to one-half or less of their normal arc of excursion. Attempts to continue passive movement beyond a certain point, especially in extension, are limited by a most characteristic muscle spasm very similar to that seen in tuberculous joints. If the spasm is overcome by force, and the wrist moved still farther, the pain is intolerable. There is no crepitus or ecchymosis, but there is seen to be slight swelling or thickening over the radial half of the wrist-joint. The outlines of the extensor tendons of the thumb are made less distinct by the swelling, and pressure elicits signs of tenderness definitely localised over the scaphoid bone, and specially in the anatomical snuffbox."

Our radiographs show that fracture of the scaphoid occurs in connection with other injuries, and is not always so simple as in the pictures I have just exhibited. Here are several varieties of such complex injuries. The first one is—

G.—FRACTURE OF THE SCAPHOID, WITH DISLOCATION BACKWARDS OF ONE FRAGMENT (FIG. 2).

The next is—

H.—AN IMPACTED COLLES' FRACTURE, WITH FRACTURE OF THE SCAPHOID.

In this case there has been some thickening about the lower end of the ulna. The fracture is evidently of long standing, for the radius is consolidated and in good position, but the wrist is disorganised, and has evidently been the seat of severe inflammation. Until the skiagraph was taken it must have seemed remarkable that the wrist was so useless when the Colles' fracture had united in such a good position. The two fragments of the scaphoid in this case are united by a thin band of callus, but there is no good union.

Here is another radiograph showing still another variety in which there is—

I.—FRACTURE OF THE SCAPHOID, WITH FRACTURE OF THE STYLOID PROCESS OF THE ULNA.

In this case the lower end of the radius seems to have escaped uninjured.

I have devoted so much time to the exhibition of the different forms of fracture occurring at the wrist that the important subjects of prognosis and treatment must be dealt with very briefly.

The prognosis depends very largely upon the diagnosis. Rational treatment can be adopted when the nature of the injury is known; otherwise we work in the dark. The series of radiographs which I have shown you warn us that fractures at the wrist are often complex, and that it is impossible to obtain a satisfactory result when such an injury is treated on the supposition that it is "only a Colles" or "merely a sprain," because the additional injury has been overlooked. It is important, therefore, to obtain a good radiograph in every case, and at the risk of "damnable iteration" I would repeat in more than one position of the limb. Broadly speaking, the prognosis is good in simple fractures at the wrist when the styloid process of the radius or ulna is not torn off, or when the fracture of either or both bones is simple and transverse. In Colles' fracture with impaction it is fairly good even when the lower fragment is comminuted, but in fracture of the scaphoid it is bad unless the injury is recognised at the beginning and treated accordingly. But the arm is needed for much more delicate movements than the leg, and therefore I would personally much rather sustain a Pott's fracture than have a broken wrist.

The first essential of treatment is to leave nothing to chance, but to bring the broken ends of the bone into the very best possible apposition, and keep them there until they are united. The impacted end of a Colles' fracture should always be separated before a splint is applied. I make this an absolute rule for your guidance. There are a few exceptional conditions where it is better to sacrifice some of the use of the wrist and leave the ends impacted, but they do not concern you now, and it is best for you to remember that every Colles' must have the deformity completely reduced as soon as possible. A Carr's splint must then be applied. It is the best form of splint for these fractures, because it is easy to make with a straight splint, to which a piece of a broom handle is screwed obliquely, and it is comfortable to wear. The fingers are bound round the end of the splint until the acute pain and some of the inflammation have subsided, and this is usually for four days. The fingers are then left free, though the splint is still bound to the hand and wrist. Once a day the surgeon or nurse moves each finger deliberately and in succession, so as to ensure the free movement of the long flexor and extensor tendons in their sheaths as they pass over the injured wrist, for in these fractures the tendon sheaths are often damaged by the presence of inflammatory products. At the end of a month the splint may be safely replaced by a leather wristlet, or in a poor person by a small bavarian splint, reaching from the point above the fracture to the middle of the hand, and the patient should be instructed to use and exercise his wrist joint, more especially by movements involving some rotation at the joint. The joint should be rubbed from the tenth day onwards if it is possible to secure skilful massage. The gauntlet may be dropped at the end of the fourth week from the accident.

But this treatment is not useful for cases of fractured scaphoid. The two fragments of this bone show very little power of union, and it is therefore necessary to take more active measures.

A fractured scaphoid is generally taken for a sprain when it occurs as the only injury to a wrist, and it is often several weeks before the patient has a radiograph taken. This may account for some of the bad results. But in the radiograph I showed you the fractured scaphoid was only a part of other injuries which must have made the immediate application of a splint a matter of absolute necessity. The radius in this case was firmly united, but the two fragments of the scaphoid are only joined by a slender thread of callus. An attempt may be made to obtain union when the scaphoid has been broken, but if at the end of a month the radiograph shows that it has not occurred satisfactorily, the patient should be advised to have one of the broken pieces removed. Experience has shown that if the united fracture is allowed to remain, the wrist becomes the seat of a chronic inflammation which makes it painful and increasingly useless. The removal is made through a small incision on the dorsum of the wrist parallel to and along the inner side of the tendon of the extensor carpi radialis longior. When one fragment of the scaphoid is dislocated, as in Fig. 2, there should be no hesitation in removing it at once.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Dr. Chantemesse, Professeur Agrégé of the Faculty of Medicine of Paris. Subject: "The Serum Treatment of Typhoid Fever (Antityphoid Opsonisation)"*

The witnesses before the Royal Commission on Vivisection last week were Dr. Swan and Dr. Cowen, on behalf of the National Canine Defence League; Mr. A. G. Scott and Sir F. Banbury, M.P., on behalf of the Royal Society for the Prevention of Cruelty to Animals; Mr. L. E. Shore, M.D., Physiological Laboratory, Cambridge; and the Hon. Stephen Coleridge, re-called, on behalf of the National Anti-Vivisection Society.

ORIGINAL PAPERS.

CASES DEMONSTRATING THE VALUE OF SPINAL ANALGESIA IN PROTECTING THE PATIENT FROM SURGICAL SHOCK.

By E. CANNY RYALL, F.R.C.S.I.,

Senior Surgeon to the Kensington General Hospital.

The object of this paper is to bring before the notice of our surgical *confrères* the absence of shock when operations such as those recorded in the following cases, amongst others, are performed under the influence of lumbar puncture.

When one considers the fatalities resulting from shock following operative interference, it is of the greatest importance to eliminate this factor, and we believe that in spinal analgesia we have the method for combating it—a method which, we regret, has not yet received the due consideration in this country which it deserves.

In these cases no pain was felt during the operations. Headaches and vomiting were absent, and the result as regards shock was ideal in all instances, notwithstanding that two of the patients were suffering from severe heart lesions, and in a third pulmonary tuberculosis in an active stage already existed.

Case I.—Suprapubic Prostatectomy.—Heart Disease.

J. K., æt. 60, first came under our care as an out-patient at the Kensington General Hospital in 1906, and gave the following history. About two years ago he began to be troubled with frequency of micturition and difficulty in starting the act. He often had pain, referred to the glans penis, and had noticed blood in his urine on two occasions. For the past two months the frequency increased, and he is now compelled to micturate every hour during the day, and to rise three or four times each night. Occasionally he has had sudden stoppage of the flow of urine.

On examination per hypogastrium nothing abnormal could be detected. Per rectum the prostate was found to be enlarged, smooth, of uniform consistence, and movable. When asked to micturate it was noticed that the stream was small and ejected with little force. After the act he was placed on a couch, his glans penis and meatus thoroughly washed, and a sterile rubber catheter passed, which drew off 3 oz. of residual urine which was alkaline, sp. gr. 1025, containing pus cells and crystals of calcium oxalate, but no blood or albumen. He was subsequently admitted into hospital as an in-patient, and on passing a cystoscope we found the prostate enlarged, and lying in the post-prostatic pouch was an oval-shaped calculus. He was kept confined to his bed and placed on a light diet. His bladder was washed out daily, and urotropine administered in combination with acid sodium phosphate, This had the effect of rendering his urine acid in reaction, and practically free from pus. He had a well-marked mitral regurgitant murmur, an impulse diffused and feeble, and a pulse of low tension. Bronchial râles could be heard over both lungs. Under these circumstances we considered that general anæsthesia should be avoided, and determined to operate under spinal analgesia.

The day preceding the operation we ordered 4 minims of liquor strychninæ to be injected hypodermically every six hours.

Operation.—On October 11th, 1906, the patient was anæsthetised as follows: He was seated on the operating table with his body bent forwards, the interval between the third and fourth lumbar spines defined, and the puncture point marked with pencil. Ethyl chloride was then sprayed on the site of puncture, and the needle of our syringe, which was made for us by Messrs. Allen and Hanbury, plunged into his spinal canal. Three cc. of a 5 per cent. isotonic novocain-suprarenin solution, containing novocain 0.15 g., and suprarenin borate 0.000325 g., was then injected, and the patient placed on his back. The bladder was then well washed out with boric lotion, and 12 oz. of suprarenin solution injected into the organ as the distend-ing medium. This solution we have now used in suprapubic prostatectomy for some years, with the object of controlling hæmorrhage and preventing shock.

Analgesia being complete over the abdomen, we made an incision above the pubes, opened the bladder, removed a calculus the size of a pigeon's egg, and then enucleated the prostate. The amount of blood lost was very small. The bladder having been again washed out, a drainage tube of 1 in. in diameter was inserted into the bladder, and gauze, covered with cellulose wadding, applied to the wound. The patient was then taken back to bed, and sensibility had returned in abdomen and legs one hour afterwards. During the operation a running conversation was kept up with the patient.

After-Treatment.—His bladder was irrigated twice daily, both through the wound and urethra; urotropine and acid sodium phosphate were given medicinally. He had no sickness or headache following the operation, and made an uninterrupted recovery, leaving the hospital bright and cheerful.

It appears to us that suprapubic prostatectomy performed under spinal analgesia with novocain opens up a new field in the surgery of this organ. We were particularly struck in this case, the patient being an extremely nervous subject, suffering from advanced heart disease, as well as in many other prostatectomies performed under lumbar puncture, with the absence of shock which is so commonly met with following this operation under general anæsthesia: and we would strongly urge operating surgeons who are in the habit of performing suprapubic prostatectomy under chloroform or ether to give this method a trial, for we feel certain that if the after-effects following the operation are as slight in their cases as they have been in ours, they will seldom make use of general anæsthesia.

CASE 2.—STRANGULATED FEMORAL HERNIA.—PHTHISIS.

A. J. K., æt. 33, was admitted into the Kensington General Hospital, on April 13th, 1907, suffering from strangulated femoral hernia. On examination, a swelling about 3 in. long by 2 in. broad could be felt in the region of the femoral canal, which was tense, tender, and without impulse on coughing. Pulse 96, small and wiry.

Frequent vomiting was present. He was very much emaciated, and both lungs were the seat of tuberculous deposit. He was suffering from shock, and his general condition most unfavourable for general anæsthesia.

A few hours after admission into hospital his dural sac was injected with 8 cc. of a 1 per cent. solution of novocain-suprarenin, 8 cc. of cerebro-spinal fluid having been first withdrawn. Five minutes afterwards herniotomy was performed. The intestine which occupied the sac was slate-coloured.

He stood the operation extremely well, and his general condition improved immensely, but, unfortunately, his lung trouble caused his death eleven days later.

CASE 3.—STRANGULATED INGUINAL HERNIA.

A. P., æt. 45, was admitted into the Kensington General Hospital in a very collapsed condition, suffering from a strangulated inguinal hernia.

His trouble commenced 24 hours before admission by the expulsion of a large mass through the inguinal canal into the scrotum. He was vomiting for several hours before he sought relief at the hospital. On examination he was found to have a large tense swelling extending from the lower part of the scrotum into the inguinal canal, which was very tender and without impulse on coughing, and could not be reduced by taxis. Herniotomy was performed an hour after his admission under spinal analgesia; 10 cc. of a 2 per cent. novocain-suprarenin solution was injected in the mid-line between the second and third lumbar vertebræ, 10 cc. of cerebro-spinal fluid having been first withdrawn and discarded. Ten minutes elapsed between the injection and the commencement of the operation, during which time a final washing of the field of operation was carried out. The sac contained a small portion of intestine, together with a large bulk of omentum. The latter was tied off in sections, and excised. The constricting ring was very small and tense, and after its division the gut and stump of omentum were replaced into the abdomen, and the wound closed in the usual way. The patient's condition during the operation was surprising. His collapsed appearance vanished, and he left the operating-room in a far better state than when he entered. He was discharged cured.

We have had similar cases of strangulated inguinal hernia which have had herniotomy performed under spinal analgesia, and in each instance there was an entire absence of shock following the operation.

CASE 4.—CARCINOMA OF RECTUM.—HEART DISEASE.

E. C., æt. 55, an extremely nervous patient, was first seen at my house on April 4th, 1907, when he stated that he had to go to stool about twenty times in the 24 hours, passing motions which were small in size, generally semi-fluid, containing mucus and blood. He was found to be suffering from advanced arteriosclerosis, with double aortic murmurs, and the apex beat displaced downwards and outwards. He had marked throbbing in the femoral and carotid arteries.

When about to make a rectal examination, we were particularly struck with the small size of his anus, and directly it was attempted to put the finger into the canal he could not bear it, although there was no fissure or other sign of disease at the orifice. It was only after using a local anæsthetic that we were able to make a momentary examination of the rectum, which revealed carcinoma, for, owing to the sensitive condition of the patient, it was impossible to make the thorough examination necessary for our guidance as to the advisability of recommending excision of the growth.

Five days later a thorough examination of his rectum was made under the influence of spinal analgesia with novocain. It was then found that the growth was fixed to the surrounding tissues, and the lumen almost obliterated. Excision was therefore out of the question, and an inguinal colostomy was advised, and subsequently performed six days afterwards. On this occasion he was also given a spinal injection, consisting of 10 cc. of a 2 per cent. novocain-suprarenin solution. Before the injection 12 cc. of cerebrospinal fluid was withdrawn by syringe suction and thrown away. Analgesia was perfect in three minutes. He bore the surgical interference well, and was chatting to us during the operation.

Within three weeks he returned home, with the artificial inguinal opening working satisfactorily.

Six days later profuse hæmorrhage from the growth in the bowel took place, and as the rectum required plugging, a third injection of novocain into the lumbar sac was given, and the bleeding arrested.

Finally, two days afterwards, a fourth lumbar puncture was made, and novocain-suprarenin solution injected. Analgesia having been produced, the gauze plugging was removed. The patient was so nervous and sensitive that he refused to allow any interference to be carried out without a spinal injection.

As this patient was suffering from severe aortic disease, and his own medical attendants refused to give him a general anæsthetic owing to the risk involved, one had therefore no hesitation in using spinal injections, and on each occasion it worked admirably.

CASE 5.—CARCINOMA OF RECTUM.—EXCISION BY THE SACRAL ROUTE.

J. M., æt. 57, was admitted into the Kensington General Hospital on September 20th, 1906, suffering from carcinoma of the rectum.

For several months prior to admission he had suffered from a constant desire to go to stool, and although he passed fluid motions containing blood and slime, he still felt a sensation as if there were something in the bowel to come away. On examination per rectum a malignant growth could be readily detected involving the circumference of the bowel, and extending beyond the reach of the finger. It was freely movable on the underlying tissues.

On September 21st the operation of colostomy was performed, and he was discharged from the hospital within a month. Before leaving, the question of excising the growth and its danger were fully discussed with him, but he could not make up his mind to have the second operation done.

On November 12th, 1906, he was re-admitted for excision of the rectum, having determined to undergo the risk of operation with the prospect of getting rid of the disease. Preparatory treatment for a few days having been carried out, on November 15th excision of the rectum by the sacral route was performed under the influence of spinal injection with 2 per cent. novocain-suprarenin solution. The operation involved the removal of the coccyx as well as the lower end of the sacrum. About 8 in. of the terminal end of the gut, including the anus, were excised, which necessitated freely opening up the peritoneal cavity. From the beginning to the end of the operation the patient frequently assured us that he could feel no pain, and throughout its performance no paleness or other change could be detected in his facial aspect. His pulse was 84 at the commencement of the operation, and 86 at its termination.

When the operation was completed and he was taken back to bed, his bright appearance and jocular manner was a complete surprise to those who saw him. He left the hospital well. We have seen him a few days ago, and there is no sign of recurrence of the growth, a period extending over twelve months having elapsed since the operation.

THE TREATMENT OF SYPHILIS IN THE LIGHT OF THE RESULTS OF RECENT INVESTIGATIONS. (a)

By E. LESSER, M.D.,
Professor of Dermatology, Berlin.

[Specially Reported for this Journal.]

Gentlemen,—Recent times have procured for us two great steps in advance as regards syphilis—the communicability of the disease to animals, and the discovery of the excitors of it by Schaudin, and the further labours of Hoffmann. By these the subject of syphilis has been placed upon quite a different basis as regards diagnosis and treatment, as these now have a basis of certainty as regards origin and animal experiment. The question, therefore, has now to be discussed: What influences have these advances had upon our views? I shall only touch upon the chief points, and shall discuss them chronologically.

First comes the much-discussed question of the excision of the primary sore. By excision are we in a position to remove all the virus, and thereby protect the system against general infection? Undoubtedly the chances are greater the earlier the excision is carried out. But, great as the chance was, the uncertainty of diagnosis was up to now greater still—so much so that we could not decide as to whether excision had prevented the general infection, or whether this would not have come on without it. Now, by proof of the spirochetæ, we are in a position to make the diagnosis early, and so form a groundwork for answering the question of the efficacy of excision. The histological examinations and animal experiments are but little encouraging as regards any good prospect from excision. But as Jadassohn properly remarks, the conditions in the inoculation of apes are different from what they are in man, and it is also to be considered that after removal of many excitors of the organism, after the analogy of other infective diseases, the comparatively few remaining excitors may suffice for further infection. That is true with one exception so far, that Finger, after excision in one case that was diagnosed with certainty, saw no secondary symptoms during two years.

A second question is: What is to be done after the excision? Formerly general treatment was not begun if there was no induration of the cicatrix, and no appearance of general secondary symptoms was indicated. Now, however, it is recommended that general specific treatment shall be begun immediately after excision if spirachetæ are found, as we cannot be sure that all the virus has been removed by the excision. Repeated courses, even, have been carried out. Thalmann has injected a 1 per cent. solution of sublimate under the primary sore with good effect. Before this, even, Weisspflug had injected a 1 per cent. solution of salicylate of mercury into the glands in 32 cases, and in 28 of them saw no secondaries after the lapse of some years. Thalmann, however, always associated his local treatment with general, so that his cases do not serve for answering the question on this point, and the large number of injections of Weisspflug are to be looked on as general treatment.

The third question is: When shall the general treatment be begun? Formerly, most were of opinion that it should be begun as soon as secondary symptoms made their appearance, for the reason that, if begun earlier, the diagnosis might be masked. We did not know whether the absence of secondary symptoms was spontaneous or due to the general treatment; whether specific induration had been present or not. Now by demonstration of the spirochetæ we can diagnose a primary sore with certainty, and masking need no longer be feared. Then it was assumed that the result of the general treatment was better when the first appearance of the general symptoms was waited for. Now the question comes up whether with earlier general treatment the virus may not be destroyed in its place of first localisation, or whether, if this cannot be done, the general symptoms, when they do appear, are not rendered milder by it. Neisser and Thalmann advocate early treatment. According to my view the question cannot be decided yet, as the time is at present too short. The better effect of general treatment after the appearance of the general symptoms has been attributed to the organism being flooded with the virus, and being thereby more accessible to attack. This view must, however, be looked upon as incorrect. From the searching investigations of Hoffmann, however, it may be taken that the flooding of the system with the virus precedes the outbreak of the general symptoms by about three weeks. According to this, mercurial treatment should be begun at this period

A fourth question concerns the intermitting general treatment for protracted periods introduced by Fournier. Most specialists have adopted this mode of procedure. As regards its propriety in the period before the discovery of the spirochetæ, in the Festschrift for Senator I attempted to put it on a basis, after Lang's method, in the following manner: The form and kind of fever show that when the infection is general, the virus is latent for a time, then, after apparent recovery, it again becomes active, because only a part of the virus has been destroyed. The latter circumstance is the cause why, in relapses, the number of disease centres becomes steadily less. The latter rule is, however, subject to one exception, that the germs present everywhere in the body break through direct into the circulation, and so lead to a sudden flooding of the system with the virus. It must therefore be the aim of all rational treatment to destroy all the disease germs.

Does mercury, then, act destructfully on the spirochetæ? According to Thalmann, the answer is yes. In favour of this is the fact that in many cases fever comes on after even the first application of the drug. The question can only be decided with certainty by the direct application to the spirochetæ. In some cases Hoffmann saw rapid disappearance of the spirochetæ after injections of sublimate, in other cases the germs were found afterwards. That mercury destroys the spirochetæ cannot be doubted, but the destruction is not always complete, even when the treatment has been protracted, as we sometimes see relapses after it. Hence the desire to find another more certain remedy. This has not been obtained yet, however, for even iodine, good as it is in the treatment of syphilis, is no substitute for mercury. The desire for a substitute for the latter is justifiable on account of the injurious effects associated with it. Here also the discovery of the excitors of the disease has led us farther on. After the action of atoxyl on various forms of trypanosoma had been established, Uhlenhuth tried it for the destruction of the spirochetæ in syphilis. The experiments first performed on apes were encouraging; then it was tried in my own clinic on two patients who were given a number of injections of atoxyl in 0.2 gm. doses. The result was negative. Lassar met with the same want of success. Later on appeared the communications of Salmon, in which atoxyl in large doses was said to be followed by brilliant results. Upon this Uhlenhuth gave doses of 0.5 gm., and satisfied himself of the good effects. Lassar also recorded recoveries with the high doses. In my own clinic I treated 28 patients with the drug (22 men and 6 women); 3 were in the primary stage, 19 had secondary, 5 galloping, and 1 tertiary syphilis. In every case a 10 per cent. solution of 0.5 to 0.6 gm. of atoxyl was injected into the muscles. A total amount of 5 to 6 gm. of atoxyl was given in each case. The result as regarded the disappearance of symptoms was good, frequently quite striking. The primary affections receded rapidly, the secondary more slowly; an iritis healed after three injections. The effects were striking in ulcerations in malignant syphilis, in sclerous glossitis, in syphilitic angina. A myelitis disappeared very rapidly after 6 injections. No specific local treatment was made use of in any case; for ulcerations, dressings of solutions of acetate of alum were applied. Sometimes a solution of atoxyl was painted on with good effect. In three cases the results were unfavourable; in one a relapse took place after 14 days. Along with these generally favourable results, however, symptoms of intoxication by atoxyl could not be overlooked. Considerable accessory effects were not unfrequently observed, such as violent colic-like pains, with loss of appetite and sleeplessness, nausea, vomiting, diarrhœa, and once nephritis with albumin and cylinders in the urine. These symptoms disappeared when the medicine was left off, and in every case returned when it was begun again. In the case of one woman opium had no effect on the vomiting and diarrhœa; no effect was produced until morphia was given with bicarbonate of soda. The observations must be continued. It was known that when other preparations of arsenic were given, arsenic was discoverable after some days, and now in one case arsenic could be found six weeks after it had been given. Generally considerable increase in weight took place after the use of atoxyl, but in three cases a loss of weight was shown, so that as a rule the effect as to nutrition was not unfavourable. After all, the verdict must be that atoxyl causes a rapid disappearance of the symptoms of syphilis, and that therefore it may be very properly made use of in cases of individual susceptibility to mercury. A conclusive judgment cannot be pronounced at present, however; that can only be done after years of trial. We must ever keep one thing before our eyes—that the risks of a remedy, however effective, must not be carried too far.

(a) Read before the Verein für Innere Medizin.

THE NEW MEDICAL SERVICE FOR THE TERRITORIAL ARMY. (a)

By SIR ALFRED KEOGH, K.C.B.,

Director-General of the Army Medical Service.

THE scheme, Sir Alfred said, is one which has been really devised by the Volunteer medical officers themselves. So long ago as 1901 a meeting of Volunteer medical officers at Edinburgh put forward practically every one of the proposals embodied in the official scheme, and more recently, at another meeting of Volunteer medical men, practically the same suggestions were then made. When he took up the position of Director-General of the Army Medical Service, his attention had been first occupied with the organisation of the Volunteers, because, as was well known to every student of military medical organisation, the existing state of affairs was far from satisfactory. There was now a declared military policy of a definitely scientific character, under which there would be an expeditionary force equipped to take the field abroad at a moment's notice; and in the absence of that expeditionary force the whole responsibility of home defence would be undertaken by the Citizen or Territorial Army. The absence of the expeditionary force implied the removal of the regular medical service of the Army, which was not, as a matter of fact, sufficiently large for the purposes of completely satisfying the needs of the expeditionary force, but was large enough to form a sufficiently good nucleus. The whole responsibility for the medical arrangements of the Citizen Army, if there were an invasion during the absence of the Regular Army, would devolve upon the medical profession. The leaders of military thought were thoroughly wide awake to the immense importance of the relation which the medical service bore to the Army. There was a time when this was not so, but military science was now being studied, and it was now clearly realised that the battles of the future were not going to be won simply at the point of the bayonet, but by the different sciences composing the Army. The duty of the medical service might be summed up in the phrase—the maintenance of the fighting strength of the Army. Our Army being comparatively a small one, made the prevention of wastage of fighting force in the field a factor of enormous value in the winning of battles. There were some who would say that there would never be any invasion, or even any threat of invasion. It was in the same spirit of unpreparedness that we had entered into all our previous wars; and, although we had always been victorious in the long run, we had invariably muddled them at the beginning. Sir Alfred proceeded to give, with the assistance of diagrams, a sketch of the operations of an Army medical organisation in the field, explaining briefly the duties of the various departments of the organisation and the system by which they were linked up. He laid particular emphasis on the value of what he described as business aptitude, and said that if the service were inefficient in this respect the wastage of the fighting force would become exceedingly rapid. Military experts calculated that the wastage of strength in our Army in the first year of a war was 80 per cent. of the total strength. A large part of this was to be attributed to medical shortcomings—lack of knowledge as to the origin and spread of disease in camps and insufficient inspection of the men in hospital, many of whom were not sent back to fight when they were fit to take their place in the line. Large numbers of men were returned home from South Africa in the late war who ought to have been in the ranks. They had heard a great deal of Army scandals in connection with that war, but, in his opinion, there were no scandals, except possibly that the supervision was inadequate to prevent a great amount of wastage. Our system of disease prevention and sanitation was defective in one respect—that the officers who were charged with the care of the hospitals were also charged with the sanitation of the surrounding area. That was utterly impossible, and for the correction of this defect they had the beginnings of a sanitary service, in connection with which there was a sanitary school at Aldershot, which in course of time would prove to be a great advantage. Another proposal was that a sanitary committee of business men should follow the troops in time of war, and assist the medical staff on the spot, instead of holding a commission of inquiry after the battle. That kind of committee would be welcomed by the medical staff. They did not do much that was wrong, and, taken all round, their performances in the South African war were a credit to the profession. In the existing medical service of the Volunteers, in many battalions there were four or five medical officers and no hospitals whatever. They had trained a number of men to pick up the wounded and to carry them. What they were going to do with them after picking them up, and where they were going to carry them, nobody could say. Civil hospitals would not do for the accommodation of the Citizen Army. If a small army of 70,000 men were sent to Liverpool, and had to be kept under canvas, it would only be a matter of a few days before there were 2,000 or 3,000 on the sick list. That condition would grow in intensity until—quite apart from epidemics—there would be 10 per cent. of the men in hospital. Obviously the civil hospitals could not accommodate them, especially as during a time of invasion there would be great depression and distress, and the hospitals would hardly have room for them.

There was no sanitary service whatever connected with the Volunteer Forces, and the conditions of the

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(a) Address delivered before a representative gathering of medical men at the Town Hall, Liverpool, on December 10th, 1907.

Volunteer Army had been admirably adapted to the exclusion of a large number of the leaders of the profession in medicine, surgery, and sanitation. Everybody who attached himself to the Volunteers was required to go into camp to make himself efficient—as if a leading physician would make himself more efficient as a physician by going into camp. It was a silly system, which was to be held responsible for many of the shortcomings of the Volunteer medical service.

Proceeding to the explanation of the medical staff scheme connected with the Territorial Army, Sir Alfred said there were to be eleven specific areas recognised under the scheme, and every division would have a medical officer on the staff of the general, from whom he would receive his orders and convey them to the staff in his area—thus securing co-ordination in the medical and military movements. With a chief medical officer of each division there should be a sanitary officer. With each battalion there should be a sanitary organisation. He proposed that every sanitary officer in the country should be asked to join that force. Without an efficient sanitary service it would not require foreigners to bowl our Territorial Army over, for when they were mobilised—coming as they did from all quarters and from all conditions of life—disease would break out much more rapidly than in an encampment of Regulars, who would come straight from the barracks, where their health was under constant supervision. He proposed also that there should be twenty-three general hospitals at the great educational centres, so that the aid of the most eminent experts in the profession could be obtained; three field ambulances, consisting of nine medical officers and a quartermaster and 230 non-commissioned officers and men, would also be required in each division. The organisation of the field ambulance would imply work in time of peace, but Liverpool had great facilities in connection with its special schools, hospitals, and educational institutions. The conditions of service would be exceedingly simple. Those who could not go into camp would be asked to do eight days' training of some kind. The days would not necessarily be consecutive, and three hours would compose each day. A consolidated corps to embrace all this was proposed for the purpose of carrying out the duties which would devolve on the medical profession in time of invasion.

CLINICAL RECORDS.

BELFAST HOSPITAL FOR CHILDREN.

CASES SHOWN AT THE LAST MEETING OF THE ULSTER MEDICAL SOCIETY, DECEMBER 12TH

By John McCaw, M.D.Dub., F.R.C.S.,

Physician to the Belfast Children's Hospital.

Evelyn M., æt. 10 years. Admitted to Children's Hospital on November 22nd, 1907. Child began to complain of headache and some cough 14 days ago. On admission nothing amiss could be found but a small patch of dulness on the right side behind on a level with middle of right scapula. Temperature has been sub-febrile since admission, never rising higher than 100° F. She was submitted to Calmette's ophthalmo-reaction, and responded markedly. This is likely tubercular enlargement of a tracheo-bronchial gland. Under treatment she has improved in general condition.

Violet W., æt. 2 years and 2 months, was admitted to hospital on November 6th last with well-marked symptoms of tetanus. The jaws are strongly set, temperature 103°. pulse 156, risus sardonicus very well marked. Antitetanic serum, obtained from the Lister Institute, London, was injected into the left abdominal wall, the dose given being 5 c.c. This was repeated on November 8th, 11th, and 16th. A notable feature was the high rate of pulse, which ranged from 180 to 160 till after the third injection of serum. On the night of the 7th, restlessness became extreme; chloral hydrate was given up to 8 grs., without effect; chloroform was then administered with good results, and she slept after it till next morning. The restlessness returned next night; chloroform was again given in small quantity, and with the same beneficial effect. The following day the spasm of the jaws was much relaxed, and she was able to swallow from a spoon, and tube feeding was omitted. After this the symptoms gradually subsided, and she made a perfect recovery. There was no wound on the body, and the only septic focus was a spot or two like impetigo on the right thigh.

Robert N., æt. 8½ years. Has complained of pain in the forehead for the last year at intervals. Latterly this pain has become much more obtrusive, and is now accompanied with well-marked cerebral vomiting. He has not had any convulsive seizures at any time; no optic neuritis. Tested with Calmette's ophthalmo-reaction, he reacted. Much improvement has followed the exhibition of pot. iodide gr. 5, with liq. hydrarg. perchlor. ½ drachm ter in die. This may be a caseous tuberculous tumour in the cerebellum. Still under treatment in hospital.

James T., æt. 9 years, was admitted to Children's Hospital 6 days ago with well-marked local asphyxia in the hands and feet, some small blisters on the feet and marks of many others that have healed. He has improved very much under 10 gr. doses of chloride of calcium.

OPERATING THEATRES.

VICTORIA HOSPITAL FOR CHILDREN.

Widespread Peritonitis from Sloughing of Appendix.—Mr. J. Cunning operated on a boy, æt. 9, who had been admitted for pain in the abdomen and fæcal vomiting. The illness began five days before with sudden abdominal pain accompanied by vomiting. His mother called in a doctor next day, who gave him castor oil. He passed a motion after the castor oil, but the vomiting and pain continued, and the vomit became fæculent in smell. On the fifth day he was admitted to the hospital. He looked very ill with a pain-pinched face and sunken eyes; his pulse was 140, his temperature 101. The abdomen was not distended, but was board-like in rigidity all over. No lump could be detected on account of the rigidity and extreme tenderness on pressure. There had not been passage of either blood or mucus. Mr. Cunning remarked that he had to deal with a case of widespread peritonitis; the persistent vomiting and its fæculent character indicated that there was intestinal obstruction; intestinal obstruction is either inflammatory or mechanical, and the extreme rigidity and tenderness was a clear indication that this was inflammatory. The absence of distension at this stage was unusual; it put out of account any question of the obstruction being mechanical. The absence of blood and mucus being passed from the rectum also put out of account intussusception as the lesion. The diagnosis of appendicitis was, therefore, the most likely one. At the operation the theatre was heated to a temperature of 80, and the patient was laid on a table heated by hot water cans, with as little exposure as possible. The abdomen was opened by an oblique incision midway between the umbilicus and the anterior superior spine on the right side. Foul smelling thin pus was evacuated. On passing a finger into the abdominal cavity, the appendix was found in Douglas's pouch; it was pulled up into the wound, and it was discovered that the terminal inch was black and gangrenous, and just proximal to the gangrenous portion was a fæcal concretion. The appendix and its mesentery were ligatured and removed. There were some indications of limitation by adhesions towards the mid line both in Douglas's pouch and in the main part of the abdominal cavity, but the pus was found to extend upwards in the renal pouch towards the liver. A second incision was made in the loin, and tubes were passed in one towards the liver and one into Douglas's pouch. As it was not known whether the other side of the abdominal cavity was affected, the right side was covered with dressings and clean gloves were donned. An incision was then made on the left iliac fossa, where pus was again found, both in the pelvis and up towards the spleen. A second tube was passed down into Douglas's pouch, and another was passed in through the left loin towards the spleen. Dressings were then applied, and the patient sent back to the ward, where continuous rectal saline was administered. The whole operation lasted fifteen minutes. Mr. Cuming said that this was a case in which suppuration had extended from the appendix into the pelvis, and then the pus had followed the usual definite tracks, that is, it had overflowed into either the renal pouch upwards towards the liver and the spleen leaving the main central portion of the abdominal cavity unaffected. These were the cases which were usually spoken of as general peritonitis when they recovered, but, of course, they were not general but only widespread. As soon as the patient recovered from the anæsthetic he would be propped up in the sitting position, so that the pus might drain from the more susceptible upper areas to the less susceptible pelvic area. The administration of saline solution by the continuous rectal method was a great help in the saving of these cases: the larger the amount of fluid absorbed the more chance there was of eliminating the toxins, and eight or nine pints in the twenty-four hours could be easily taken up by this method. With regard to the gangrene of the appendix he thought the concretion had produced either an abrasion or an actual ulcer: this formed a focus of entry of a virulent brand of either bacillus coli or streptococci which had caused so much inflammation and exudation that the circulation of the terminal inch of the appendix had been cut off. It should be remembered that the terminal third of the appendix had no mesentery, and that its circulation had to be carried on by vessels running along its wall, so that any violent inflammation at or about the termination of the mesentery, if it produced much swelling, would cut off the circulation beyond that area.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Clinical Section.

Meeting held December 13th, 1907.

The President, Sir Thomas Barlow, in the Chair.

Dr. Edgar Reid (introduced by Prof. W. Osler) showed a case of

OCHRONOSIS.

F., æt. 68. A large ulcer on each leg had been dressed twice daily with carbolic oil, 1 in 20, during a period of 30 years. Six years ago the ears and whites of the eyes began to turn black, and two years ago the urine was first noticed to be dark. In June, 1907, the concavity of each ear was stained a deep blue-black, and the sclerotics were stained black in their exposed portions. The extensor tendons of the fingers were bluish-black in colour over the knuckles, and the latter showed a slight blue staining. The skin of the face and exposed parts was of a dusky hue as compared with the covered parts.

Prof. Osler discussed the case, and pointed out that carbolic acid poisoning had been noted in the four last recorded.

Dr. A. E. Garrod had examined the urine, and, from the observation that 85 per cent. of the sulphates were in the aromatic form, had concluded that the patient was a potential carboluric, although no carboluria was actually present. He remarked that all the previous cases had had either carboluria or alkaptanuria—*i.e.*, one or other hydrokinone derivative, and this pointed to a common origin for all the cases.

Dr. Parkes Weber discussed the early diagnosis of such cases, and pointed out the confusion that might arise between cyanosis and hæmatochronosis.

Prof. William Osler showed a case of

SPLENIC POLYCYTHÆMIA WITH CYANOSIS.

Patient was a hard-working woman, in whom, within the past two or three years, there has been slight failure of health and strength. She was permanently cyanosed. She presented in an unusual degree the three characteristic features of the disease: a permanent cyanosis, a greatly enlarged spleen, and a polycythæmia of 10,000,000 red blood corpuscles. There was no increase in the leukocytes, and no marked variation in the size of the red blood corpuscles. There were nucleated red cells in moderate numbers, chiefly normoblasts.

The first case of this kind had been published by Vacquez. Since Prof. Osler's paper in 1903, some 40 or 50 had been recorded.

Dr. R. G. Hann referred to a case characterised by great splenic enlargement, polycythæmia, recurrent attacks of diffuse abdominal pain, but with no cyanosis.

The President considered that the absence of cyanosis in Dr. Hann's case excluded it from the present group. He referred to a case he had recently seen in which the vasomotor changes were very marked.

Dr. Parkes Weber mentioned that in one of his cases there had been a great number of normoblasts. In all the autopsies so far there had been found infarctions with perisplenitis, which might account for the occurrence of abdominal pain.

Dr. William Pasteur had had a case recently of splenic enlargement accompanied by periodic abdominal pain. Post-mortem there was neither infarction nor perisplenitis.

Mr. T. H. Openshaw showed a case of

TRAUMATIC DISLOCATION OF HIP, IN A BOY OF 15, REDUCED BY MANIPULATION AFTER THIRTEEN MONTHS.

Dr. F. Parkes Weber showed a case of

ARTERITIS OBLITERANS OF THE LOWER EXTREMITY, WITH INTERMITTENT CLAUDICATION.

M., æt. 32. Complained of cramp-like pains in the sole of the left foot and calf of left leg, occurring after walking for a few minutes and obliging him to rest. When the legs were allowed to hang over the side of the bed the distal portion of the left foot became red and congested-looking. No pulsation could be felt in the dorsal artery of the left foot or in the posterior tibial. The disease had lasted about five years, without real gangrene supervening.

Dr. W. Essex Wynter showed a case of

METHÆMOGLOBINÆMIA OF TWELVE YEARS' STANDING.

F., æt. 45. (Under observation since March, 1902.) Had been in the same state of cyanotic anæmia for twelve years. There was a general yellowish pallor, with lilac-coloured mucous membranes, associated with feebleness, constipation, anorexia, and occasional vomiting. A pulmonary systolic bruit existed while the patient was in hospital. Urine normal. Blood chocolate-coloured, making comparison difficult in the hæmoglobinometer; the colour was not altered by exposure to CO; red cells, 3,010,000; white cells, 7,000; hæmoglobin, 50 per cent.; index, .74; white corpuscles normal; bacillus coli not found in blood.

Dr. Poynton had seen this case at St. Mary's Hospital twelve years ago, and the condition was then, if anything, worse than to-day.

Dr. C. R. Drysdale asked whether there was evidence of blood destruction in this case, as sometimes occurred.

At the President's suggestion, a committee consisting of Dr. Drysdale, Dr. Garrod, Dr. Poynton, and Dr. Wynter was appointed to investigate the case further.

Dr. W. Essex Wynter showed a case of

AMYOTONIA CONGENITA.

F., æt. 15 months. Admitted to Middlesex Hospital, September 21st, 1907, on account of general weakness and backwardness. The striking feature in the condition was the flabbiness of muscles and freedom of movement in articulations, allowing of flexion and extension beyond normal limits, so that the toes could be made to touch the front of the leg and the fingers the back of the forearm, while the legs could be flexed up to the chin. The child could sit up and walk, and was cheerful and intelligent. The muscles did not contract to strong faradism, and moderate currents induced no pain.

Dr. **Morley Fletcher** raised the doubt that the case might be one of severe rickets affecting chiefly the muscles.

Dr. **Ernest Jones** remarked on the deviation from the title of myotonia, originally given by Oppenheim, to the condition.

Dr. W. **Essex Wynter** showed a case illustrating

CURE OF ASCITES BY PERMANENT DRAINAGE THROUGH THE FEMORAL RING.

M., æt. 50. Admitted to Middlesex Hospital, July 11th, 1907. For a week there had been swelling of abdomen and legs, with slight jaundice. The diagnosis was hepatic cirrhosis. The ascites increased, and on August 26th tension was relieved by removing 300 ozs. of fluid. This was only of temporary benefit, and on September 23rd Mr. Sampson Handley made a small incision below the umbilicus and several pints of fluid escaped. An incision as for femoral hernia was then made, and with the aid of one finger in the abdominal cavity the process of peritoneum was drawn down, split, and the edges stitched right and left to maintain the opening. The wounds were then closed. The ascites did not recur, and by November 20th there was no perceptible fluid in the abdominal cavity. The patient had been walking about the ward for a fortnight, and neither femoral hernia nor œdema of the leg had developed.

Mr. **Sampson Handley** described the operation. He had had to open the abdomen so as to reach the femoral ring.

Dr. W. **Pasteur** showed a case of

ANTERIOR POLIOMYELITIS, WITH PERMANENT PARALYSIS OF THE DIAPHRAGM AND ABDOMINAL MUSCLES.

M., æt. 13½. Illness began in November, 1906, fever and delirium. Two days later there was loss of power in lower limbs; paralysis spread, and mother noticed that boy could not cough; arms not completely paralysed. On admission on eightn day, November 19th, there was flaccid paralysis of the lower limbs; the diaphragm was paralysed; respiration entirely thoracic; abdominal muscles paralysed; abdominal and epigastric reflexes absent; paresis of all muscles of upper limbs. For ten days the condition was critical; artificial respiration performed every two or three hours; inhalations of oxygen and hypodermic injections of strychnine given frequently. From March until the present time the condition had remained as follows: complete recovery of power in upper limbs; considerable recovery of thoracic muscles; persistent paralysis of diaphragm, abdominal muscles, and muscles of lower limbs.

Dr. F. J. **Poynton** showed

TWO CASES OF THYROID SWELLING IN YOUNG GIRLS.

The first was a typical case of Graves's disease in a girl æt. 15. The second case was that of a girl æt. 14 who had been treated for cretinism as an infant. Whenever thyroid treatment was omitted within six weeks, the following symptoms appeared: (1) a swelling in the neck, obviously the thyroid; (2) mental dulness; (3) slowness of speech; (4) enlargement of the tongue. Resumption of the thyroid caused the disappearance of all these symptoms.

Four weeks ago the patient, who has been steadily treated ever since these attempts, showed a definite thyroid swelling. There were no symptoms of Graves's disease. At present no increase had been made in the amount of thyroid given, and the neck still showed the swelling.

The diagnosis inclined to is partial cretinism, with compensatory enlargement of an inefficient thyroid to supply the lack of secretion when the outside supply is slowly cut off.

Dr. J. **Graham Forbes** showed a case illustrating an unusual form of gouty deposit in the left olecranon bursa in a man æt. 34. No evidence of gouty deposit about great toe joints.

Prof. **Osler** remarked that such deposits might be the only sign of gout apart from even the usual tophi.

Dr. Poynton said that microscopically it was clear that the primary change in these cases was a necrotic one, and that the deposit was secondary.

Dr. **Parkes Weber** contrasted the cases in which the reaction to irritation was mainly a fibrous one with these in which marked tophaceous deposit occurred.

Dr. **Garrod** thought that surgical measures in such cases were valuable provided the joints were not involved. The olecranon bursa was a favourite site for tophaceous deposit.

Dr. H. **Batty Shaw** showed a case of

BULBAR PARALYSIS.

F., æt. 47. For twenty years had had a large bronchocele and slight attacks of periodic huskiness of the voice. In June, 1907, half the bronchocele was removed, as the pressure on the trachea was increasing; it presented the microscopic structure of carcinoma.

July 8th, voice almost completely lost; stridor; weakness of left lower facial muscles. July 15th, pain and stiffness of back of neck. August 21st, atrophy of right half of tongue noted. August 28th, diplopia. November 5th, paresis of sixth nerve on right side, paresis of right half of palate, paresis and atrophy of the right sterno-mastoid and trapezius; aphonia; could swallow solids with difficulty; paresis of left lower facial muscles and complete paralysis of left vocal cord; vomiting had recently occurred. The diagnosis lay between primary degeneration of the centres of the various nerves involved, possibly due to thrombosis, and a secondary deposit in and about the medulla. The latter view was supported by the presence of severe pain and stiffness of the muscles of the back of the neck.

Dr. H. **Batty Shaw** also showed a case of

HEPATO-SPLENOMEGALY WITH ASCITES.

F., æt. 3½, was noticed to be short of breath in June of this year. She was now easily tired and unable to walk far owing to shortness of breath. The abdomen was observed to be swollen on November 22nd of this year, and this has increased steadily.

There were no signs of tuberculosis or of syphilis. The liver was enlarged and the spleen was felt easily. Jaundice had not been observed.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Surgery.

Meeting held Friday, November 29th, 1907.

Mr. E. H. Taylor in the Chair.

Intrameningeal Hæmorrhage.

Mr. R. Atkinson Stoney presented a patient whom he had trephined for intrameningeal hæmorrhage. The following were the notes of the case:—Patient, L. M., æt. 44, admitted to Royal City of Dublin Hospital on Tuesday, September 3rd, 1907. History of falling on back of head in street while drunk the previous Saturday; he seemed none the worse at the time. On Sunday evening began to get drowsy and stupid; this condition was increased on Monday. On admission he was dazed and stupid; he could not speak properly; started to answer a question, and then began to talk nonsense; pupils were equal, contracting to light; pulse, 65-70; temperature, 99°; very restless; no mark of injury; complained of pain in right occipital region; reflexes normal. On Thursday patient seemed better; speaking more distinctly; still very restless. Continued to improve till Tuesday, 10th, when he began to get drowsy and stupid again. He was worse on Wednesday. On Thursday morning quite unconscious; pulse over 100; colour somewhat blue; pupils equal; very sluggish. In the middle of day pupils very small, equal, not reacting; pulse over 120 and very weak; moving all his limbs; knee-jerks absent; Babinski's sign present on both sides; saw patient twitch right arm once; did a lumbar puncture, and drew off a test tube full of clear fluid; slightly relieved by this for about half an hour, then got worse again. Trephined over left parietal eminence; dura mater bulging, dark blue, and not pulsating; on opening it found a thin layer of clot and dark fluid blood; could not feel any laceration or fracture, though felt both petrous portion of temporal bone and orbital plate of frontal. At end of operation pupils were larger, reacting to light, and brain pulsating; pulse, however, was bad, but improved after infusion of three and a half pints of saline solution; patient was better in the evening; swallowed a few mouthfuls of milk with difficulty. On the next day (Friday) pupils were reacting; complete paralysis of right arm was found; knee-jerks absent; plantar reflexes normal; pulse varying from 100 to 120. On Saturday, very bad in early morning; at 1.30 pulse was 140 and very weak; bad colour, and respirations bad; dressed the case; flap was very prominent, not pulsating; on taking down the flap, found no clot, but brain was prominent and not pulsating; vessels were congested; put a needle about two inches into brain and drew off test-tube full of clear fluid under considerable tension; brain receded somewhat and pulsated feebly; eyes reacted better; pulse and colour were better. When dressed next day, flap not so prominent; appeared slightly conscious; recognised wife and brother. Gradually improved, and began to use right hand on Tuesday. On following Sunday a note to say can use right arm well. At present patient appears in perfect health; normal movement of arm; but some difficulty in pronouncing some words and complete inability to read, though able to write and recognise all objects.

The **Chairman** asked if there was any hæmorrhage going on during the operation, and whether it was on account of the oozing of blood that the drainage tube was introduced. He was also anxious to know if Mr. Stoney's view of the bulging of the brain afterwards was that it was due to distension of the lateral ventricle, or whether he considered there was any œdematous condition of the brain tissue itself. Mr. Stoney had not stated the cause of the marked depression of the scalp over the area corresponding to the part that had been removed.

Mr. **Blayney** said the case was a puzzling one, in view of the history that had been given. The typical history of intrameningeal hæmorrhage was that the patient became unconscious, and did not become conscious again; but in the case before them the patient did not lose consciousness when he met with the fall. One would imagine that violence sufficient to produce hæmorrhage inside the skull would have caused unconsciousness. Then there was a prolonged period in which there were no signs of increased intracranial tension. He thought the bulging of the brain after the operation was due to some inflammatory phenomenon.

Mr. **Stoney**, in reply, said he had brought the case forward in the hope of eliciting some explanation of the sequence of events, as he had to confess he found it difficult to do so himself. The history had been difficult to obtain, as the man was drunk at the time of the accident, as well as everyone who was with him. So far, however, as he could make out, there was no loss of consciousness at the time of injury. When the signs of increased pressure began to appear, he thought it was the commencement of œdema of the brain, and he was under the impression that operation offered little hope of improvement, but he felt that the localising signs justified an attempt to find out their cause. On opening the dura mater there appeared to be no fresh hæmorrhage, and on exploration he could find no laceration and no fracture. He was doubtful as to whether the hæmorrhage occurred at the time of the injury, the symptoms of increasing compression being due to œdema of the brain, or that the hæmorrhage had occurred later on and was producing the symptoms of pressure by itself. He thought the protrusion of the brain was mainly due to the collection of fluid in the lateral ventricle. A useful point in the case was the fact that it showed that the descriptions in the books of typical cases of intrameningeal hæmorrhages could not be entirely relied upon. It showed also that cases of head injury should never be looked upon as hopeless.

Mr. W. I. **de C. Wheeler** exhibited a case of ascites from hepatic cirrhosis cured by the Talma-Morison operation performed three years ago. The patient had been frequently tapped before the operation, and drained through an exploratory laparotomy wound, but without any beneficial result. For about three weeks after the epiplopexy fluid collected, and a small amount has persisted, neither getting more nor less for the past three years. The patient, who weighed about 7½ stones before operation, now averaged 11 stones. The amount of fluid withdrawn by paracentesis before the radical operation was performed approximated two gallons per fortnight for three months. Mr. Wheeler considered this case an ideal one for operation for the following reasons:—(1) Previous tappings and laparotomy failed to give relief; (2) progressive emaciation and the appearance of slight jaundice was a warning against further delay; (3) the exploratory laparotomy revealed an attempt by Nature to anticipate the operation by the formation of adhesions; (4) the liver was enlarged, not atrophied, and therefore sufficient liver cells remained to carry on life; (5) there was an absence of an cardiac or renal complication. The great number of successful cases recently published were referred to, and the absence of the true "hob-nailed" liver and of an alcoholic history in so many cases commented upon. Mr. Wheeler considered that the efficacy of the operation was no longer in doubt.

Mr. **Haughton** said his experience of the operation was limited to two cases, which he described.

Mr. R. C. B. **Maunsell** quoted a case in which the operation had proved unsuccessful, in which a markedly cirrhotic kidney was found at the post-mortem.

Mr. **Benson** asked if there was any cirrhotic condition in any other part of the patient's body, as he had seen a case of a lady who had cirrhosis of the lung eight or ten years previous to the condition of the liver coming on. He thought it might add to the patient's comfort if he were tapped to get rid of the fluid that still remained.

Mr. **Stoney** and the **Chairman** also recalled cases of the operation.

Mr. **Wheeler**, in reply, said the patient had nothing in the way of cirrhosis in any other organs, but the last time his urine was examined it showed signs as if he was getting cirrhosis of the kidneys. He was not inclined to do anything more in the case as long as the man remained in his present condition. The fluid still remaining was the same in amount as it was at the time of the operation.

Mr. **Seton Pringle** exhibited a case of mucous colitis in which he had performed appendicostomy some months ago. The patient, a strong labouring man, with no sign of neurosis about him, sought treatment some two years ago for an uneasy burning sensation in the lower bowel and rectum, some pruritus ani, and the passage of a quantity of mucus in the stools. He was found to have hæmorrhoids, and these were removed by operation, but he returned some two months later worse than ever, and now the whole motion was often composed of cylinders of mucus. A course of treatment, consisting in daily irrigation of the large bowel with astringents and antiseptics, was then commenced, and persisted in for months, the patient at the same time being dieted and stomach sedatives, etc., given by mouth. As the treatment resulted in no improvement, Mr. Pringle performed appendicostomy last June in order to enable the whole large intestine to be systematically washed out. After giving a short history of this operation and describing its performance, Mr. Pringle pointed out that many cases of cure of mucous colitis by its aid had been reported, and so far no failures. Since last June the patient has washed out his own colon daily with various antiseptics, and latterly has been using argyrol 1 in 1,000 in the morning and normal saline solution at night, but Mr. Pringle regretted to have to report that the condition was in no way ameliorated, and he regards the treatment in this case as a complete failure. In conclusion, he called attention to the fact that the bowel had been examined carefully with the electric sigmoidoscope, and no gross lesion found, so that this is apparently a true case of mucous colitis, and not one of those cases of ulceration, kinking or growth which often so closely simulates this disease.

Mr. **MAUNSELL** said he considered the operation a most useful one. He suggested that if the medical treatment did not cure the patient, an ileo-sigmoidostomy might be successful, in which case the excluded piece of gut could be resected subsequently.

Mr. **BENSON** thought ipecacuanha might be tried.

The **SECRETARY** thought that, notwithstanding recorded cases, the operation was not a very successful one in cases of mucous colitis.

Dr. **STEVENSON** asked if any difficulty was experienced in keeping the aperture from closing, and whether the catheter was kept in the whole time.

Dr. **PUGIN MELDON** said that a weak solution of peroxide of hydrogen would clear away any foreign matter in the intestines; mixed with borax and bicarbonate of soda it might do some good.

Mr. **HAUGHTON** instanced a case of operation for ventral hernia which caused the disappearance of colitis that had been treated for a long time medically without success, and he raised the question as to whether Mr. Pringle had satisfied himself that there was no reflex cause for the disease in this case.

Mr. **PRINGLE**, in reply, said he would seriously consider the question of further operation if the suggested medical treatment proved of no avail.

Mr. **MAUNSELL** presented the case of an elderly man on whom he had operated for a carcinoma of the floor of the mouth. By the time the patient presented himself for treatment the growth had involved the tongue, and was extensively adherent to the jaw. The operation consisted of removal of half the tongue and a portion of the jaw, extending from the neighbourhood of the middle line to the last molar tooth. At a subsequent date the lymphatic glands on the same side of the neck were exposed, from the angle of the jaw to the clavicle, and removed. At the latter operation very considerable trouble arose in connection with the taking of the anæsthetic, probably due to the removal of the levators of the larynx at the previous operation.

The **CHAIRMAN** said there was no doubt that the probability of permanent benefit from operation for cancer of the tongue was not at all great, particularly in such a case as that before them. He expected that Mr. Maunsell's idea was to make the man's life more endurable, supposing that glandular recurrence came on after the removal of the disease in the mouth. In operating on parts far back in the mouth he recommended the performance of a preliminary laryngotomy. He thought it enabled them to work easier than where the patient had to breathe through the mouth. In a recent case, in which he had performed a preliminary laryngotomy, he found there was no anxiety about the hæmorrhage. Although Professor Kocher's recent method was only a modification of an old method, he considered it a great advance.

ULSTER MEDICAL SOCIETY.

CLINICAL MEETING HELD IN THE MEDICAL INSTITUTE, BELFAST, ON DEC. 12TH.

The President, Dr. **JOHN McCAW**, in the Chair.

COLONEL J. R. DODD, F.R.C.S., and Captain E. P. Connolly were elected Fellows of the Society, and Drs. S. R. Hunter, Foster Coates, and R. Jamison were elected Members.

Dr. **ALLEN** showed a case of coloboma of the iris and choroid.

Mr. **ROBERT CAMPBELL** showed a case of malformation of one great toe.

Dr. **A. B. MITCHELL** showed a boy of 8 suffering from an obscure nerve lesion of several months duration. There was a most peculiar gait and staggering movements, but no loss of power. There had been optic neuritis, and there was now atrophy. On the whole the general opinion was that the case was one of cerebellar tumour.

Dr. **CECIL SHAW** showed a child of 9 suffering from a peculiar thickening or chemosis of the conjunctiva in one eye This was situated high up under the upper lid, and had persisted unchanged for some three months in spite of various local applications. Dr. Cecil Shaw also showed a girl of 15 with extensive ulceration and cicatrization of the pharynx and soft palate of four years' duration. No history of syphilis in the family could be found, nor any other signs of syphilis in the girl.

Dr. **McKISACK** showed a case of exophthalmic goitre in a young woman. As her symptoms grew steadily worse during two months of medical treatment in hospital, surgical interference was decided upon, and half the gland was removed by Mr. Robert Campbell, since when there had been a distinct improvement.

Dr. **RANKIN** showed a series of cases undergoing X-ray treatment for lupus and epithelioma.

Dr. **JOHN McCAW** showed 4 cases, which will be found in another column under heading "Clinical Records."

Dr. **DEMPSEY** showed a tumour weighing 27 lbs., which he had removed from a woman lately.

Professor **SYMMERS** and Dr. **A. E. MITCHELL** exhibited specimens of primary sarcoma of the pancreas, and secondary deposits in the left ovary, liver, and right lung.

Mr. **HANNA** showed the brain of a child who had been submitted to a radical mastoid operation, and afterwards developed purulent cavernous sinus thrombosis. No abscess was found in the brain.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, DEC. 12TH, 1907.

The President, Mr. R. **MARCUS GUNN**, in the Chair.

THE following is an abstract of Mr. Nettleship's paper on

SOME CASES POSSIBLY ALLIED TO TAY-SACH'S INFANTILE RETINITIS.

It was suggested that the amaurotic family idiocy of Waren Tay and Sachs, although usually fatal in infancy, and limited to children of pure Jewish origin, might sometimes be milder, allowing the child to live several years, or even to grow up, and that many families of "Gentiles" contained more or less Jewish blood. The author thought that cases such as those described by Dr. F. E. Batten, Mr. Mayou, and others, in which amblyopia, with slight changes in the macular region, came on a few years after birth, and was sometimes associated with progressive cerebral degeneration, might be mild examples of Tay's disease. Also that the same might be true of certain cases of amblyopia counted as congenital, in which there was central defect in the field, and sometimes nervous or mental failure, but no tendency to early death. In the best marked of these cases there was colour-blindness, often total and complete, and day-blindness, but in the less severe ones there might be no colour defect and no dislike of strong light. All these forms of non-fatal amblyopia were, like Tay's disease, liable to run in families.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Dec. 15th, 1907.

URÆMIA.

THE clinical forms of uræmia are very varied and differ according to individual cases, yet there is a certain number of symptoms which are common to all varieties.

The quantity of urine, for instance, is always diminished at the period of uræmic accidents, but it varies in degree according to the cause of the uræmia. In uræmia following acute or subacute nephritis (parenchymatous nephritis) oliguria is very pronounced even to anuria. On the other hand where the subject suffers from interstitial nephritis the quantity of urine may be almost normal, considering that during the course of the malady and before uræmic symptoms had set in, the patient urinated two or three quarts daily.

Parallel to oliguria, urea diminishes considerably and frequently albumin increases, but not constantly.

Generally speaking, the temperature falls progressively below the normal, especially where the malady is approaching a fatal termination.

Arterial hypertension accompanies constantly uræmia and the pulse becomes slower; this bradycardia is nearly always observed in the chronic forms.

In certain cases the sight is affected with slight amblyopia or even complete amaurosis. The principal characters of this last accident lie in the fact that it is independent of any ocular lesion, appears suddenly and is always transitory, disappearing after the attack.

Of all the nervous symptoms, headache is the most important and the most frequent, resembling frequently migraine. The headaches, says M. Chauffard, are intense, continual, or intermittent, accompanied by vertigo and inaptitude for all intellectual work.

Among the cutaneous troubles observed in the course of uræmia may be mentioned pruritis, eczema, urticaria, erythema, and in some case a kind of frost produced by urea covers the skin under the form of small white crystalline flakes; it is always a grave sign, and is observed only in the last stages of uræmia.

The above symptoms are general to all forms of uræmia, but when the acute symptoms set in they affect chiefly the nervous system, the respiratory apparatus, or the digestive tract.

The nervous troubles consist in convulsions, delirium, and coma, which is the final stage.

Convulsions can complicate all varieties of nephritis, but they are especially frequent in nephritis following scarlatina, and principally in children and in parturient women (eclampsia).

Delirium is observed generally, according to Dieulafoy, in persons predisposed to mental disturbance, either from alcoholism or from some hereditary taint.

Coma is the natural termination of all other nervous forms of uræmia. In some cases it sets in gradually, preceded for several days with a sensation of heaviness in the head, the patient becoming apathetic and somnolent.

In other circumstances it strikes the patient suddenly; he falls and remains unconscious. This apoplectic attack has been studied by Raymond; it generally affects persons of a certain age suffering from chronic nephritis which had remained latent and only brought into evidence by the attack. The patient succumbs almost immediately; it is an important cause of sudden death. Brouardel used to say that sudden deaths from kidney affection were much more frequent than from any other cause.

The respiratory symptoms of uræmia are dyspnœa *sine materia* or that associated with, and more or less dependent on, bronchitis and pulmonary congestion.

The former may consist in a simple sensation of oppression, or it may be acute resembling attacks of asthma when the patient is seized with anguish and a sensation of impending death. The respiration of Cheyne-Stokes is observed in the last period of chronic nephritis, and constitutes a symptom of great gravity.

As a general rule, the existence of uræmia should be suspected in every patient of over 40 years of age who suffers from dyspnœa.

Lasègue describes three types of bronchitis due to albuminuria.

In the first, the patient complains of intense dyspnœa, coming on in paroxysms, and especially at night; it is due to an attack of pulmonary œdema.

The second type is characterised by dyspnœa, coming on suddenly; cough is frequent, and expectoration is mucous; crepitating râles are perceived by auscultation.

In the third form bronchitis is general, cough frequent, and expectoration abundant

Besides these forms there remains acute œdema of the lungs. Suddenly, and generally at night, the patient is seized with acute dyspnœa, the face is cyanosed, cold sweats cover the body, and expectoration, spumous and sanguinolent, is exceedingly abundant. Fine râles, which invade rapidly all the chest, like the incoming tide, according to the expression of Renaut, are heard by auscultation. The pulse becomes thready, the heart becomes weakened, and the patient succumbs rapidly unless he is bled promptly.

The digestive symptoms of uræmia consist of furred tongue, vomiting, and sometimes diarrhœa. Vomiting is one of the most constant signs; the patient rejects at first food, and afterwards has bile and mucus. The amount of liquid rejected in the 24 hours is sometimes very considerable. Chronic uræmia is observed chiefly in persons over 50 years of age, already suffering from chronic or instertitial nephritis. The premonitory symptoms are those already mentioned—headache, intellectual apathy, insomnia, troubles in the respiratory rhythm, attacks of nocturnal dyspnœa. According to Fournier, inappetence, vomiting, diarrhœa, succeeding to a prolonged period of constipation, are the constant symptoms of chronic uræmia.

Acute uræmia is met with chiefly in the course of acute nephritis, and particularly in children. It is also observed in individuals who have suffered from latent chronic nephritis, which was suddenly manifested by uræmic accidents.

Acute uræmia frequently has for its only symptom sudden coma (apoplexy). Individuals, says M. Castaigne, who in the midst of their occupations—frequently even while at table or immediately after—fall suddenly and die in a few minutes. Such cases are frequently observed in asylums for the aged.

The treatment general to all forms of uræmia is that of nephritis. The patient, who should be recommended to avoid all cold or brusque changes in temperature, is put on milk, given drastic purgatives, diuretics, intestinal antiseptics (benzo-naphtol), and enemas of cold water. Such is the treatment of the attenuated form of uræmia.

In the graver and complicated forms the treatment should be more energetic. Blood-letting for coma, eclampsia, and acute œdema of the lungs, inhalations of oxygen gas, small doses of morphia, subcutaneously if the dynspnœa is not relieved, or inhalations of nitrite of amyl. Pills of ipecacuanha (1 grain), and opium (1-10th grain) may be given until nausea sets in.

The vomiting and diarrhœa of uræmic persons should, in general, be respected, as they remove the toxines which the kidney cannot eliminate. Where it is judged necessary to arrest one and the other, it is generally sufficient to place the patient on the hydric diet (a quart and a half of boiled water daily) for two or three days.

GERMANY.

Berlin, Dec 15th 1907.

The Prussian Minister for Medical Affairs has recently issued an ordinance directing midwives to use creosol soap as a disinfectant in place of lysol, the one in use before this.

The creosol soap is directed to be made in the following manner: 60 parts of linseed oil are to be heated in a water bath in a roomy, loosely closed vessel; then is to be added under agitation the following solution—viz., 12 parts of potassium hydroxyde in 30 parts of water and 12 of rectified spirit. The mixture thus formed is to be heated to complete saponification, and when this has taken place 100 parts of creosol of a boiling point of 199° to 204° C. are to be added. The resulting liquid must be clear, and of a yellowish brown colour. It is to be marked "For external use only." It must be used in a 1 per cent. solution only, and must be prepared for use in the following manner: A litre of lukewarm water to be poured into a clean dish or bottle, and 10 grammes of the creosol soap are then to be added under agitation. It must never be prepared for use in a tinned or painted vessel.

The Sleep of School Children.

The School Physician, Dr. J. Bernhard, has recently issued a report on this subject after an examination of 6,551 children. He reports that for all ages from 7 to 15 years of age the time the children get for sleep is far behind their physiological requirements. This shortage of sleep he attributes to the work the children are required to do at home, such as carrying out parcels, street trading, etc. Only one-third of the children have a bed each; the rest sleep two or three, or even four, in a bed.

At the Hufeland Society Hr. Ewald showed the Reactions of the Bence-Jones' Albuminous Bodies, which are derivatives of albuminosis. In very slightly warmed urine a cloudiness takes place at a temperature of 37° to 40° C. This becomes stronger on further heating. By still further heating, however, the urine becomes clear again. The process was the reverse, therefore, of that which took place with albumen.

The patient from whom the urine was obtained was a man, æt. 56, who came from Russia, and presented the following symptoms: He had suffered for years from mitral insufficiency. He had complained lately of pains over the region of the left breast, great weakness with distension of the abdomen. There were no œdematous swellings, and no other noticeable disturbances. The abdomen was distended in a peculiar manner, just like an india-rubber cushion. A tumour the size of a small apple could be felt between the umbilicus and the left ribs. Tapping of the sternum, tibia or bones of the arm caused no pain. There was complete absence of free and combined hydrochloric acid in the stomach contents. Digestion imperfect. In the urine, which was of a sp. gr. of 1,010, were the above-mentioned albuminous bodies precipitated by ricinic acid, and to an extent of 1 to 3 per cent. The fundus oculi was free. There were no typical changes whatever in the blood; with the exception of a small increase of the lymphocytes the blood was quite normal.

The diagnosis was based on the urine alone. The appearance of Bence-Jones' albuminous bodies had been associated with various diseases, all of them connected with the bony system. According to Ellinger, they were cases of chondro- or lymphosarcoma, which appeared in a multiple form within the bones, but which were not visible outwardly. According to the speaker, two forms must be distinguished, the one presenting the form of chronic osteomalacia, in which easily palpable bony changes were present; the other ran its course with symptoms of gradually increasing weakness. The case shown belonged to this category. The condition of the urine was in favour of this. Cases of true Bence-Jones' albumosuria were very rare. The lymphosarcomata developed either in the bone marrow or in the abdomen. There was no demonstrable ascites, but some fluid was certainly present in the abdomen. During the last few days the patient had complained of pain in his left arm, and had vomited several times.

The treatment of such cases was indicated pretty plainly: injections of atoxyl, and Röntgen-ray treatment over the spleen every second day. The results were apparently favourable. The number of lymphocytes had diminished, but this might be accidental.

Hr. Benda communicated a short note on

Periarteritis Nodosa and Periarteritis Syphilitica.

Attention was first drawn to these subjects in 1866 by Kussmaul and Maier. The clinical features of the affections were obscure. The symptoms were those of a labourer who had previously been healthy, and who had gradually faded away with marasmus. At the autopsy numerous small vesicles were found on small vessels and widely distributed over the internal organs. On closer examination small aneurysms were found, in which the external layers of the vessels participated. Up to 1904 17 such cases had been collected. Three publications on the subject had appeared during the past three years. The pathological conditions were the same in all cases—viz., a widespread aneurysmosis of the smaller arteries passing on to the larger ones. There was a tendency to thrombosis, and to a change in the other organs. The cerebral arteries had escaped attack except in one instance; all the other arteries were liable to become implicated. In two cases observed by the speaker a diagnosis of chronic nephritis had been made. In one case there was hypertrophy of the left ventricle, emphysema and symptoms of stasis; in the other cirrhosis of the liver. In this case death was brought about by hæmorrhage into the abdominal cavity. The diagnosis had never been determined with certainty during life, and only once had a microscopical examination confirmed the suspicion.

AUSTRIA.

Vienna, Dec. 15th, 1907.

Angioma Arteriale Racemosum.

Clairmont reported the history of a case on which he operated for a racemose angioma on the head. He commenced the operation by incising the circumference of the tumour, and then dissected the vascular swelling from before backwards. Fourteen days after the operation the patient took an epileptic fit; the fits have repeated themselves since that time. They seem to be due to the distension of the intra-cranial vessels from the collateral circulation.

Radio-Therapy of the Ischias.

Freund exhibited a case of ischial neuralgia of a persistent character that resisted all sedative drugs, but yielded to irradiation. The sacrum and foramina were exposed only twice to the rays, when comfort was obtained, and after the sixth application the pain disappeared completely. He recorded the history of other five similar cases, with equally beneficial results. He thinks these happy results are obtained by the Röntgen rays dilating the vessels and relieving the contractile fibres around the nerve.

Relation Between Lymph and Glycosuria.

Biedl gave the Association a lengthy demonstration of the close relationship between glycosuria and lymph circulation by cutting of the chylous and lymph currents by ligature on the ductus thoracica, which produced glycosuria. From this he concludes that there is a principle in the lymph that has the power of transforming the saccharine principle into a glucoside, which is eliminated in the form of glycosuria. This substance in the lymph is the product of some internal organ, and has the power of regulating the transformation in the organism.

Cranio-Plastic Operations.

Lotheissen next showed the members a child over two years old with a defect in the cranial bones, measuring 7 by 5 centimetres. The history of this defect led to the conclusion that it was the result of a traumatic cephalic hydrocele. He first commenced by a periosteal flap from bone according to the Muller-Konig method, which did not succeed. He next adopted the Hacker-Duraate method, which is to induce a subaponeurotic flap to take the place of the dura mater, but with no better result. In hopeless despair he resorted to transplanting cartilage from bone, but with no more success.

Fleishmann thought this was a case where the dentine was absent as in rhachitis. In this disease the calcareous changes take place early and linger long.

Tænia Cucumerina.

Koenigstein showed a child whom he was treating for tænia. For two months past the child had been passing segments which were diagnosed as cucumerina. He had passed into the stomach by means of a tube ½ gramme of extract filicis maris in a syrup of peppermint, but the half of it was soon after vomited. A metheglin or hydromel was next prepared and administered, bringing away three of the worms entire, which confirmed the diagnosis.

According to statistics about 50 per cent. of these cases arise from children playing with cats, but in this case no direct contact with either cat or dog could be traced. Is it possible that the infection was carried by external parasites such as fleas, which have been proved to carry one of the tænia's transitory forms?

Pemphigus Contagiosus.

Koenigstein presented another case, a child, six months old, with large circular and poligonal markings on the body with different colours. From its age he thought the bullæ could not be pemphigus neonatorum, but rather Escherich's pemphigus infantum, or more generally speaking pemphigus contagiousum from the well-known infectious nature of the disease. Nurses and mothers convey the infection easily. In the Leipzig Children's Hospital in 18 months out of 400 children 98 were infected with the disease. Koch records 30 children in one neighbourhood where the infection was undoubted. The bacterium found is a staphylococcus pyogenes, which when cultivated and inoculated produces the disease.

Clinically, as well as anatomically, this disease differs from the pemphigus chronicus of the adult. It differs from impetigo contagiosa from its efflorescence, rapid formation of pus, and from its not attacking the face, soles of feet, and palms of hands.

HUNGARY.

Budapest, Dec. 15, 1907.

At the recent meeting of the Budapest Interhospital Association, Dr. Rozsa presented a patient with

Stricture of the Œsophagus.

The patient began to have difficulty in swallowing, with regurgitation of food, about one year ago, necessitating eventually a gastrostomy. This operation was done in the St. Rochus Hospital, with apparently a good result. An œsophageal bougie could not be passed beyond the level of the junction of the manubrium with the gladiolus. He had the patient swallow a large amount of bismuth, and then made a radiograph, which showed the obstruction, and to the left of it a tumour. The obstruction was a saccular one. After the passage of steel sounds, the man was able to swallow milk, but at present was feeding himself through the gastrostomy wound. This case showed the value of X-ray and bismuth for diagnosing these conditions.

Chemistry of Chronic Nephritis.

Dr. Kovàcs concludes, from the chemical examination of the blood, kidneys, and various other organs, particularly with reference to the chlorides, as follows: In health the amount of chloride of sodium in the kidneys generally exceeds that in the blood and the other organs. In a large number of cases of nephritis the difference is still more marked, but exceptions are common, especially in the early stages. The amount of salt in the blood and tissues in nephritis is usually above normal; yet there are many cases where the opposite holds, despite the presence of œdema, albuminuric retinitis, and uræmia. The percentage of chlorides found in the pericardial, pleural and peritoneal fluids of nephritis is not constant. Since higher figures were obtained with the transudates of other conditions, it is improper to conclude that transudation in nephritis is a result of retention of salt. There can be no question, however, that there is a decided retention in the kidney of chlorides, sodium potassium, calcium and magnesium. In the early stages of nephritis the blood and tissues contain less water and more solid residue, but in the later stages this is no longer constant.

The Origin of Acute Miliary Tuberculosis.

Dr. Kuthy carefully investigated all the autopsy records of four years in order to decide how a local tuberculous process generally becomes disseminated. In 95 per cent. of the cases tubercles of the vessels or of the thoracic duct were found which had permitted the bacilli to gain the blood-stream. It is well known that Rippert strongly opposes this theory, since he has frequently hunted in vain for tubercles large enough in the walls of the vessels in his cases to account for the large number of metastatic deposits in the body. Furthermore, he states that the focus is not always ulcerated, and that the different size of the tubercles, especially in the lung, argues for a different age. It seems more probable to him that an active proliferation occurs into the capillaries, and that the blood is constantly contaminated from this source. The author states, however, that the capillary focus is generally inadequate, and that it is often present even where there are no miliary tubercles is due to the fact that the same number of bacilli is not transported to all parts of the body, and that different tissues do not permit an equal development.

Pyramidon in Tuberculosis.

In the internal section of the St. John Hospital in Budapest the fever of consumptives is managed as follows: As soon as the patients reach the hospital, they are put to bed. If the fever does not disappear spontaneously after five to six days, he receives 20 centigrammes of pyramidon in half a glass of water, which he is instructed to swallow slowly during half an hour after his mid-day meal. If effective the dose may be diminished after several days, while sometimes it may be necessary to give more. With inverse type of fever, the drug must be administered during the early morning hours. Bad after-effects are rare, and never amount to more than urticaria, profuse perspiration, or darkened urine. A marked improvement will be noticed in the condition of the patients as soon as the fever has disappeared; they will increase in weight rapidly, and the process in the lungs will tend to recede.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

Public Health.—The Public Health Committee of the Corporation have submitted to Mr. Birrell the following points which they wish included in the Bill he is expected to introduce next Session:—(1) To establish municipal dispensaries for the treatment of tuberculosis; (2) medical examination of school children, as in England; (3) to obtain control of all milk supplies, whether coming within their district or not, including the inspection of dairies, and cattle in them; (4) to establish and operate plant for the sterilisation and pasteurisation of milk, including purchases and sales; (5) to insure their sanitary officers against sickness and death from infectious disease; (6) to compensate persons stopping employment on account of infectious disease; (7) to provide for the appointment of a deputy medical superintendent officer of health in the absence or illness of the medical officer; (8) to require that all district medical officers of health should be qualified by the possession of a diploma in sanitary science; (9) the Committee are of opinion that the milk provisions, including the ice-cream clause of the Public Health Amendment Act Bill, which were struck out when the Bill was before Parliament last Session, should be reintroduced; also that power should be given them to maintain persons removed from their homes to temporary places while their homes were being disinfected. As will be seen, these recommendations open up many broad and controversial questions, and, if adopted by Mr. Birrell, would give new and far-reaching powers to the Public Health authorities, which might easily be abused. Their adoption *in toto* is, however, far from likely.

LETTERS TO THE EDITOR.

"THE BROWN DOG" INCIDENT.

To the Editor of The Medical Press and Circular.

Sir,—There is no analogy between the slaughter of a bullock in an abattoir and the death of the "Brown Dog," for the simple reason that no law exists, that I am aware of, as to the time or manner in which a bullock should be killed. Had we such a law, and the slaughterer treated it with contempt, no doubt he would be prosecuted, and a well-merited punishment result. There is such a law for the victims of vivisection; allow me to repeat it:—"The animal must be killed immediately the object of the experiment is obtained." Out of the vivisectors' own mouths we know this law was flouted, for the object was obtained after the second operation, and no juggling with anæsthetics can make the third operation other than a transgression of this law, and therefore illegal. Had the Home Office done its duty, and not been a mere tool in the hands of the vivisectors, their prosecution ought to have followed.

I am, Sir, yours truly,

Dec. 15th, 1907. Frances E. White.

To the Editor of The Medical Press and Circular.

Sir,—Your correspondent, Frances E. White, is perfectly correct. On the evidence of Messrs. Starling and Bayliss, the brown dog was vivisected three times. For some two months it was kept without exercise, and in a more or less mangled condition, in a cage. In contravention of humanitarian provisions in the Act, Professor Starling, instead of its being killed "in a perfectly legal and proper manner," handed over this dog to Mr. Bayliss, who in his turn failed to see that the dog was killed as required by the Act; and, as far as the evidence at the trial shows, the sworn testimony left the manner of the dog's death a mystery, the evidence being contradictory and unsatisfactory. You, Sir, however, now tell us that when you wrote that the dog "was destroyed in a perfectly legal and regular manner," you simply spoke of the death of the dog. Let us have none of that juggling which you dislike so much. Will you, as you know, tell me (what could not be discovered at the trial) when the dog was actually killed, by what means, and by whom?

I am expressing no opinion as to the advisability of the erection of the statue, or the taste displayed by the inscription thereon. The latter may or may not be "libellous." But if "the greater the truth, the greater the libel" holds good, and this is a libel, it is about as big a libel as one can think of. But you, Sir, posing as a champion of legality at times, ask "would the anti-vivisectionists have preferred another dog to have been used instead?" Why, most certainly, yes! And for two reasons—first, because, though we desire to repeal the Act licensing vivisection, we desire, in spite of the example of certain "highest authorities" (as Sir William Church would say) that an Act should be obeyed and its provisions respected; secondly, a fresh dog would in any case be preferable to the lengthened spinning out of the doing to death of this brown dog. As to serums, I am only a layman, but for years I have studied the *ipse dixits* of responsible practitioners and experimenters, and I know something of their own accounts of results achieved in cases of diphtheria, with and without its use. I think you will easily find some dozen high authorities who have produced excellent cures without the results of animal experimentation in diphtheritic cases? I have no time to supply you with information in detail, and which you can easily discover yourself. One would like to know your opinion of medical students who behave as some did at Acton, and used stink-pots for ladies' annoyance? Hoping you will give us your exclusive knowledge of the brown dog's death simply and clearly with no juggling, so very distasteful to us all, and I propose to trouble you no further.

Yours, etc.,
GEORGE W. F. ROBBINS.

The Battersea General Hospital
(The Anti-Vivisection Hospital), London, S.W.
Dec. 12th, 1907.

[We have published Mr. Robbins' letter in full, except for one sentence consisting simply of abuse which we thought better to delete. Mr. Robbins admits he is a mere layman: we therefore feel absolved from arguing technical medical points with him. The value of anti-toxin in diphtheria, of course, is admitted by every physician experienced in fevers. If Mr. Robbins will do us the compliment of reading THE MEDICAL PRESS AND CIRCULAR for the last few weeks, and also for this, he will ascertain our opinion about the student disturbances. With regard to the dog's death, we repeat that it was destroyed in a "perfectly legal and proper manner." If anti-vivisectionists wish to labour the point of the demonstration being given on a dog which was under an anæsthetic used for a previous operation, there was no doubt, on the face of it, a technical breach of the Home Office regulations pertaining to that particular certificate. Nothing but disingenuousness could distort it into anything worse. Being fond of dogs ourselves, we would like as few to be used for experimental purposes as need be. When an animal is under an anæsthetic, it can make no difference if two operations lasting, say, half-an-hour each, are performed, or one lasting an hour. If Mr. Robbins prefers two dogs to be used when one would do, to our mind that shows that he cares more for "getting at" his opponents than for animals' lives. The fact of the matter is, neither operation killed the dog in question, but it was subsequently destroyed in the adjoining room after the demonstration was over. To say that it was "done to death" is equivalent to a charge of improper killing.—ED. M. P. AND C.]

THE PROFESSION AND THE PUBLIC.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is remarkable that no fewer than five letters in your correspondence pages of this week have direct or indirect bearing upon the question of the present position of the profession in relation to the public. First there are the anti-vivisection contributions on the "Brown Dog" disturbances. There cannot be any doubt that the students' demonstrations merely express, whether foolishly or not, the indignation which every member of the profession must feel with regard to the torrent of calumny to which medical men are being systematically treated by anti-vivisection fanatics and their blind followers. These fanatics, although sometimes disclaiming the intention, are virtually engaged in a well-organised campaign carried on by active agents throughout the length and breadth of the land, in which the main argument of speakers and writers virtually holds up the whole profession to execration as the supporters of "vivisectors," "anti-human wretches," who devote their lives to the infliction of unspeakable torture upon poor dumb brutes, well knowing that the results must be of more than doubtful value. They often charge the bulk of doctors with callousness and cruelty due to the training which they imagine students go through. The anti-vaccinationists are carrying on another campaign hardly less widely and actively. These fanatics charge the whole profession—those who duties do not include vaccination as well as those who are called upon to perform the operation—with carrying on for paltry gain a gigantic conspiracy through which a loathsome poison is disseminated among the people, including their own children, whom they sacrifice to cloak their hypocrisy. The other letters which you print to-day on "The Midwives Act," "Proprietary Medicines," "Medical Law," and "Quack Methods," simply illustrate from other various standpoints the position of degradation and political impotence in which the profession stands. Vast masses of the public have become imbued with ideas which make them look upon the profession with suspicion and dislike, if not with hatred.

Is it necessary that, to use the vulgar phrase, the profession should take all this lying down? I do not know, but this I do know, that if the present state of things be allowed to continue it must become more and more difficult, as time goes on, to bring into the profession men of honour and of self-respect. I do not think I can be exceptional, and in my own case I have persuaded my son, a boy of uncommon talent with a bent towards science and to a career as a medical practitioner, to abandon his intention in favour of some avocation less likely to lead to humiliation and unhappiness. If the position of the profession cannot be improved it will soon become impossible for anyone to succeed in it from the worldly point of view unless he lower himself to the intellectual level of his patients, make up his mind to pander to popular prejudices, and deliberately adopt the principles and practices of dishonourable charlatanism. I enclose my card, and subscribe myself,

Yours, etc.,
ANOTHER OBSCURE PRACTITIONER.

December 12th, 1907.

HUMANITARIAN ABATTOIRS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The City Corporation are to be congratulated upon having at last taken action in the matter of slaughterhouse reform, and we note with satisfaction the inauguration of their commodious abattoir at Islington, in which up-to-date and humane methods of killing will be employed.

The Humanitarian League has been working for this reform for years, and is at the present time urging upon the London County Council the need of establishing abattoirs in the place of the many private slaughterhouses which exist within the metropolitan district. The advantages of public over private slaughterhouses, both for hygienic reasons and humane, have been repeatedly demonstrated by recognised authorities, official and otherwise. Many years ago Sir Richard Thorne Thorne, Medical Officer of the Local Government Board, recommended the abolition of private slaughterhouses and the substitution of well-ordered abattoirs in which it would be possible to enforce an efficient scrutiny as to the fitness of the meat for human consumption. The same conclusion was arrived at in the Report of the Royal Commission on Tuberculosis in 1898; also in that of the Public Health Committee of the L.C.C. in 1899, and at a conference of sanitary authorities held at the County Hall on July 7th, 1904, on the subject of the Administration of the Public Health (London) Act.

In view of this, and of the fact that municipal slaughterhouses have been established in a number of provincial towns in many parts of the United Kingdom, as well as on the Continent, there is the more reason why the L.C.C. should no longer postpone the carrying out of its own Public Health Committee's recommendation, to the effect that, "as a first step towards ensuring the proper inspection of meat, private slaughterhouses should cease to exist in London."

I am, Sir, yours truly,
JOSEPH COLLINSON.
Humanitarian League, 53, Chancery Lane, W.C.,
November 13th, 1907.

THE THERAPEUTICAL SOCIETY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent, Dr. Burnet, refers to some rule of the Therapeutical Society hindering open discussion. There is no rule, however, which relates to the publication of any of its proceedings. The restrictions which were imposed by the then Council have been removed by their departure into the calm refuge of the Royal Society of Medicine. I imagine the delay in resuming meetings is due to want of a secretary. Do you happen to know of one?

I am, Sir, yours truly,
A FELLOW.
December 12th, 1907.

THE NATURE OF THE SOUL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In reference to your article (December 11th) mentioning my appearance in *Black and White*, I surely need hardly say that it was not there either directly or indirectly through any of the few business qualities I possess. The exciting cause may be traced to a paper on "The Psychology of Crime," which I read recently before an *élite* medical audience, at which some distinguished laymen were also present.

I shall feel obliged if you will review the paper next month, when it appears in the *Journal of Mental Science*, and devote a little space to the criminal question in your valuable and influential columns.

I am, Sir, yours truly,
22, Langham Street, W., ALBERT WILSON.
December 16th, 1907.

OBITUARY.

THOMAS GLASBROOK DAVIES, L.R.C.P., L.R.C.S.ED., L.F.P.S.GLASG.

WE regret to record the unexpected death of Dr. T. Glasbrook Davies, of Manselton. Dr. Davies was only taken ill last Thursday, but somewhat serious symptoms showed themselves on Saturday night, and it was seen that he had pneumonia. Notwithstanding his illness, Dr. Davies insisted upon attending to a young man who was injured last Sunday morning, and this possibly aggravated his case, as the weather was very bad. He succumbed at his residence in Courtenay Street, Dr. Davies was only 39 years of age, and was exceedingly popular, and great sympathy is felt with his bereaved widow and relatives. It was only about two years ago that he married a daughter of Mr. David Glasbrook, Morriston.

LITERARY NOTES.

MR. CORNWALL ROUND has published a third edition of his little tract, "Self-Synthesis a Means to Perpetual Life" (London: Simpkin, Marshall and Co., 1907, pp. 32, price 1s.), in which we have found much to interest us. The author discusses the influence of the sub-conscious on the conscious mind, or, as he prefers, the subjective on the objective mind, and shows to what an extent the life and conduct may be altered by self-suggestion. He carries his views to an extreme point in maintaining that death is merely the result of suggestion received from others, and that therefore it may be avoided by a stronger self-suggestion. The author gives examples of some of the ways by which self-suggestion may be practised.

⁂

THE Caxton Publishing Company announce a work in the press, an "Atlas of Obstetrics," to which the stereoscopic method has been applied throughout. The work is edited by Dr. Barbour Simpson and Mr. Edward Burnet, M.B., Ch.B., of Edinburgh. The work will be on the same lines as "The Edinburgh Stereoscopic Atlas of Anatomy." Its aim is to provide a permanent record of things "as they are seen"; to supply a complete set of types of normal and abnormal pelves; and to illustrate the mechanism of labour in a manner unapproached by any other method of demonstration. Professor Sir J. Halliday Croom contributes a preface to the work.

⁂

WE have received a "Household Emergency and Reference Chart" from Major R. J. Blackham, R.A.M.C. This chart is designed to convey, in a graphic manner, practical directions for action in a variety of emergencies likely to occur in everyday life, and it gives us pleasure to say that the author has certainly fulfilled his object. The information is conveyed in language which cannot fail to be understood by any person of average intelligence, and this fact, of course, contributes greatly to the undoubted value of Major Blackham's scheme. While the chart has a wide field of applicability, we recommend it in particular to parents, school teachers, and to all, in fact, who have the care of children. It would be well if every household and school were provided with a copy.

REVIEWS OF BOOKS.

ON PNEUMONIA (a).

THIS small work is really the substance of clinical lectures and demonstrations delivered by the author at the West London Hospital to post-graduates. So much has been written on this subject that it is difficult to find anything new to say regarding it. Referring to the connection of pneumonia with influenza, Dr. Hood suggests that the attack may be of the nature of a lung paresis, and, judging from the physical symptoms, the state is one of rapid œdema or passive engorgement. He quotes actual cases bearing out his contention. The distinction between ordinary and influenzal pneumonia is that in the latter form asthenia and copious perspiration are more common, the range of temperature is not uniformly so high, and is far more irregular. The difficulties of diagnosis are very fully dealt with, and illustrative cases introduced.

As to treatment, there is no specific. Dr. Hood wisely insists on the necessity of abundance of pure, fresh air as an essential part of the treatment. Coal-tar compounds are condemned. He has a good deal to say regarding the treatment of fever, and mentions that pure, fresh air will often quickly influence the pyrexia in many cases. Tepid sponging is the best remedy against restlessness and insomnia. If drugs are needed chloralamide is one of the best. Sulphonal and veronal are often disappointing in their results in such cases. Dr. Hood has found digitalis to be of little service, but strychnine "is certainly one of the most useful drugs we possess," while oxygen is often a valuable adjunct to treatment. Those who have to treat pneumonia—and what general practitioner has not?—will find in Dr. Hood's teaching much that is practical and common-sense. It is thoroughly sound, and appeals at once to the reader. Many suggestions as to diagnosis will also be gleaned from this small volume, which we have perused with much interest and no little satisfaction.

(a) "Some of the Clinical Aspects of Pneumonia." By Donald W. C. Hood, C.V.O., M.D, Cantab, F.R.C.P. Lond.; Senior Physician to the West London Hospital. London: John Bale, Sons, and Danielsson, Ltd.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Remarks on the Theory of Chorioepithelioma.—Eden (*Journ. Obst. and Gyn.*, December, 1907).—After reviewing most of the literature on this subject, and giving notes of a case, the writer sums up the whole question as follows: Chorioepithelioma is a form of malignant growth which occurs in both sexes. It is very much more frequent in women than in men, and pregnancy is its most potent predisposing cause. In women it usually arises from fragments of chorionic tissue, normal or abnormal, which have been retained from a previous pregnancy. It may, however, occur in women independently of previous pregnancy, and in such cases its origin cannot at present be explained. In men it is generally, perhaps invariably, of teratomatous origin. F.

The Menstrual Function: Its Influence upon Chronic Inflammatory Conditions of the Appendix.—Reder (*Amer. Journ. Obst.*, November, 1907).—Why should the menstrual function provoke an attack of appendicitis? The menstrual function can only provoke an acute attack in an appendix that is chronically diseased. The menstrual function must be considered as an habitual functional hyperæmia, and as such must be looked upon as the causative factor. After a painstaking consideration of cases, I can state that only in the severest forms of adnexal disease can the inflammatory condition communicate itself to the appendix, and cause the primary acute attack. It is in the chronic form of appendicitis, be it a catarrhal or an interstitially diseased appendix, where a pelvic hyperæmia can arouse the dormancy of a smouldering appendix and provoke the clinical manifestations for acute attack. Why a smouldering appendix should show activity one, two, or three days before menstruation, and remain quiescent at other times, is a difficult matter to reason out satisfactorily. I have come to the conclusion that such an appendix can show activity independently of the menstrual function provided the proper conditions exist favourable to an attack. Why have not these patients suffered any acute attacks at a time when the menstrual function was not in evidence? Equilibration of the metabolic forces is essential to the maintenance of health. These women are in good health, and only at the time of their periods do they suffer from this abdominal pain. We must infer from this that there is a sufficient force of the element of health in the body to keep in check the microbic action of a diseased appendix. I assume that upon this principle it may be explained why acute attacks have not occurred in these women during their intermenstrual periods. On the other hand, at the time of menstruation, every woman suffers more or less from a systemic depression. Through anatomical channels and often through pathologic tissue changes; the appendix must share in the congested condition of the pelvic viscera, and such an influx of blood to a surrounding appendix is an incentive for bacterial activity. It could be expected that through the lowered vital resistance the obsonic power of the blood would be reduced, thereby favouring the pathogenic microbes harboured in the stagnant secretions in the lumen of a diseased appendix, or that through the lymph channels have found lodgment in the walls of the organ. F.

Phlebitis Following Abdominal Operations.—Pfaff (*Amer. Journ. of Obst.*, November, 1907).—After discussing the etiology of post-operative phlebitis, and stating it occurs in about 2 per cent. of cases, the writer, in conclusion, says it seems to him we are justified in accepting as facts:—(1) Many of these cases are simply extensive blood clots, without any true inflammation; (2) an abnormal plasticity of the blood must be present in order that thrombosis may be the result of surgical traumatism; (3) the clot generally receives a mild form of infection introduced into the wound at the time of the operation, and in turn an invasion of the vein wall results; (4) as stagnation is such an important element in the etiology, getting our patients up earlier will undoubtedly reduce the liability to thrombosis; (5) as an abnormally high degree of plasticity of the blood is essential in developing the disorder, the blood ought to be tested by some recognised standard in every case, and if found in a dangerous state, operation should be postponed until medication shall have brought it back to a normal condition. F.

Treatment of the Puerperium.—In an interesting paper on this subject Kroemer (*Deutsche Med. Wochenschrift*, 1907, Nr. 1-4) begins with the prophylactic measures which ought to be taken to prevent disturbance during the puerperium. When there is a pathological vaginal secretion during pregnancy, he recommends shaving and thorough disinfection of the vulva with at the same time vaginal douching twice daily with sublimate solution 1 in 2,000. In such cases also, internal examination must be avoided if possible. He does not agree with Zweifel's proposition that blood clots should be removed from the vagina post partum. When the lochial secretion is profuse and smells badly, the vulva must be particularly well disinfected, and the vagina douched with peroxide of hydrogen or potassium permanganate. He warns against internal disinfection when labour is progressing spontaneously. Before operative delivery the field of operation must be cleaned with lysol 1 per cent. solution, if the vaginal contents are decomposed and smelling. If the uterus is probably the seat of the cause of the fever, it must be douched out after the operation with alcohol. In order to prevent relaxation of the abdominal walls and its consequences, the author advises that the patient shall wear an abdominal belt from the sixth month of her pregnancy. The skin must be taken care of by baths, etc. Varicose veins must be treated with bandages, baths, and massage. He also recommends Prochownik's diet. The women should practise during pregnancy to use the bed pan in bed. If there has been any crushing of the bladder, for example after difficult forceps or pubiotomy, a catheter must be kept in the bladder during the first eight days, and the bladder douched daily. Immediately after labour the abdomen is to be bound from the trochanters to the costal margin. Towards the end of the puerperium any retroflexion or descent must be corrected with a pessary. He warmly recommends Bier's treatment for mastitis. He impresses the importance of combining, in cases of puerperal sepsis, the removal of any infection from the uterus with a careful inspection of the perineum, the vulva, the vagina, and the cervix. When retention of portion of the placenta is suspected the uterus should be examined digitally, and, if necessary, curetted with a large blunt curette. If in cases of thrombo-phlebitis operative measures are decided on, he advises laparotomy and ligature of all the four veins. He binds himself to nothing as regards total extirpation of the septic uterus. For the general treatment of puerperal fever he recommends nuclein, and at the same time subcutaneous infusion of normal saline solution to increase the leucocytosis, and quinine or ergot to excite the uterine contractions. He also recommends the serum treatment. G.

The Signification of Slow Pulse with Rise of Temperature during the Puerperium. — Merletti (*Ginecologia*, 1906, Nr. 4) states that in some cases in which the temperature rises very often to a considerable height while the pulse rate remains practically normal the prognosis may be regarded as favourable, and he then proceeds to arrange the causes which he has experienced of this condition. It is especially associated with intestinal disturbances, on the one side diarrhœa and on the other constipation with absorption of toxic substances, also with lochiometra for example in cases of pathological anteflexion of the uterus, and also in cases of pure nervous disturbances. The author gives several examples for each of these kinds of fever, and especially interesting is the history of a puerpera in whom the great anxiety to nurse her child and the daily fiasco of trying to accomplish this was associated with a high temperature up to 40 degrees. The most important and the most frequent is the intestinal fever; it begins not infrequently with a rigor and can reach a great height, while the pulse rate remains normal or rises very slightly. The author believes that when the pulse is slow in spite of a high temperature, and when there is no proof of disease in the generative tract, the presence of a serious puerperal condition need not be considered, and that such local treatment as uterine douching, etc., is useless and should not be employed. G.

The Cysts of the Corpus Luteum.—In an extract from an article on this subject, Grusdew (*Zentralbl. für Gynäk.*, 1907, Nr. 50) is reported as having stated that ovarian abscesses, malignant neoplasms, and cysts develop in the corpus luteum, and that the cysts are the most frequent. The cysts which have been described so far were usually about the size of an apple. The author operated on and examined a cyst of the corpus luteum as big as a man's head. The corrugated appearance of the inner surface of the tumour was badly developed, and the lutein layer was absent. This is to be explained according to the author by the great size of the cyst and the excessive thinning of its walls. In addition to this the author has observed two cases of hæmatoma of the corpus luteum. In both cases multiple cystic degeneration of the corpus luteum and excessive production of lutein cells were to be observed in the ovaries. There was no appearance of malignant deciduoma in the genital tract. These cases prove in the author's opinion that a hæmatoma of the corpus luteum may reach a large size, even as large as a child's head. The contained blood comes from the capillaries of the lutein cell layer. The epithelium which lines the interior of cysts of the corpus luteum is in some cases the morphologically altered endothelium of the capillaries of the lutein layer. G.

Necrosis and Suppuration in Myomata.—O. v. Franque (*Zeitsch. für Geb. und Gyn.*, Bd. LX., Hft. 2) reports three cases of necrosis in uterine myomata. In the first case of these, the necrotic tumour had perforated into the uterine cavity, and was partly expelled into the vagina, while in the second patient the uterine contraction produced by the necrotic tumour had caused a perforation of the external wall of the uterus into the abdominal cavity, and in the third into the layers of the broad ligament. The age of the patients varied between 31 and 49 years. They all recovered after operation. In another case suppuration occurred in a large interstitial uterine myoma. The patient, æt. 51, III.-para., had had the menopause. The most remarkable point was that the suppuration occurred one year after the menopause through the blood stream without any apparent cause. The following are among the author's conclusions:—The sub-febrile temperatures so frequently observed in cases of total necrosis of interstitial myomata are to be regarded as a result of absorption of pyogenic substances from the necrotic masses. In all cases of soft myomata, hooking up of the tumour must be avoided during operation, in order that the rupture of the capsule with its possible disastrous results may be avoided. G.

On December 9th there was announced the result of the poll of the 747 governors of Hampstead General Hospital regarding the proposed amalgamation of the North-West London Hospital with that institution, as suggested by the King's Hospital Fund. The in-patients' department of the North-West London Hospital has been closed, but the out-patients' department, it is proposed, should be continued as a branch of the Hampstead Hospital's work, the latter institution to have staff consultants, like other general hospitals. Much feeling has been aroused amongst Hampstead medical men on the latter proposal. The poll resulted in 195 governors being in favour of the amalgamation, and 187 against.

Medical News in Brief

Royal College of Surgeons, England.

At a meeting of the Council held on Thursday last, Mr. Henry Morris, President, in the chair, it was determined to advertise the vacant office of Conservator of the museum, and to invite candidates to send in their applications before February 1st next. A report was received from the Museum Committee recommending certain alterations in the standing rules relating to the office. A report was received from the Board of Examiners in Dental Surgery regarding a resolution adopted by the British Dental Association at its annual meeting with reference to the period of instruction in mechanical dentistry. Upon the recommendation of the Board of Examiners, the Council determined to adhere to their regulation prescribing not less than two years' instruction. The Board further reported that they had considered the application from the University of Leeds for the recognition of the dental department of that University, and the Board being satisfied that the requirements of the College had been complied with in regard to the appointment of the staff, the scope of the courses of instruction, and the opportunities for hospital practice, it was decided to add the University to the list of dental schools recognised for the education of candidates for the Licence in Dental Surgery of the College. Mr. Clinton T. Dent, Surgeon to St. George's Hospital, was re-elected a member of the Court of Examiners. The report on the annual meeting of Fellows and Members, and the resolutions carried thereat, was postponed to a future meeting of the Council.

The President reported the proceedings of the General Medical Council at their recent Session, and a vote of thanks was given to him for his services as the representative of the College. He further reported that he had been asked and had consented to serve on a Committee of that Council which has been appointed to ascertain what legal provisions exist in the Colonies and Dependencies of the Empire and in foreign countries for the prevention of medical practice by other than legally qualified persons, and to consider what steps should be taken to procure effective legislation for the same purpose in the United Kingdom of Great Britain and Ireland.

With reference to a letter from the Deans of the medical faculties of the Universities of Leeds, Liverpool, and Sheffield, suggesting the desirability of holding the primary examinations for the Fellowship at other times of the year than May and November, the Chairman of the Committee, to whom the letter had been referred, stated that the Committee proposed to postpone their report, with the object of ascertaining the views of the several medical schools upon the proposed change before submitting any recommendation to the Council upon the subject.

Murderous attack on a Medical Man.

Henrietta Fitzgerald, 30, described as a machinist, living in Burton Crescent, was charged on remand, before Mr. Mead, at Marlborough Street Police Court, on Saturday, with having maliciously wounded Dr. Ernest Cranmer Hughes by striking him on the head with a hammer.

The woman, who was well dressed, was accommodated with a seat in the dock. She, it appeared, fancied she had a grievance against the doctor, and, meeting him in Dean Street, Soho, on November 22nd, struck him on the head with a hammer, injuring him so severely that he had to be taken to Guy's Hospital. When she was arrested she exclaimed, "I wish I had killed him. I meant to have a revolver, but didn't have enough money."

Dr. Hughes now for the first time attended court, and gave evidence. He said he was assistant surgeon at the Lock Hospital, Dean Street, Soho. He first saw the prisoner the last Friday in August, when she was suffering from a certain disease. During September he received two letters from her, which he answered. He went away for his holidays, and when he returned in October he again saw her in Dean Street. She asked him for a certificate with reference to an operation she fancied had been performed on her, but which had not, and he refused to give her one. Subsequently he received a letter from the Registrar of the General Medical Council. He handed the letter to the secretary of the Lock Hospital. Afterwards he was asked to attend a meeting of the board of the hospital, and after the matter complained of had been investigated, nothing was done. From the letters he received from her he thought she might be insane. On November 22nd, just after he left the hospital, the prisoner came up to him and said, "You are Mr. Hughes, are you not?" He replied "Yes." Whereupon she struck him on the arm with a brown paper parcel, which contained the hammer produced. She became very excited, a crowd collected, and he was going to give her in charge. While looking round to get a policeman she struck him on the left side of the head, just above the ear, with the hammer.

Mr. Mead committed the prisoner for trial at the Central Criminal Court.

The Army and Navy Male Nurses' Association.

THE object of this co-operation is to afford to the public the opportunity of engaging thoroughly well-trained male nurses and sick attendants of assured good character. The *personnel* of the society is composed solely of retired non-commissioned officers and men of the nursing section of the Royal Army Medical Corps, and of members of the sick berth staff of the Royal Navy. No man's name is entered on the register as a nurse until he has obtained his certificate of three years' training in the military hospitals, or, in the case of the Navy, until he has completed his first term of service, and unless he can furnish the fullest evidence of good character. The selection of men for admission on the register is made by the executive committee after the fullest examination of each candidate's records and testimonials. The co-operation will be able to supply, in addition to male nurses, asylum attendants, masseurs, dispensers, valets or travelling attendants, laboratory and hospital porters, P.M. porters, operating theatre attendants, and assistants in X-ray and electrical departments of hospitals. It is estimated that the sum of £2,000 will put the society upon a sound basis, and enable it to commence work at once. All communications to be addressed to the Hon. Secretary, Miss Ethel McCaul, R.R.C., at the offices, 47B, Welbeck Street, Cavendish Square, London, W.

Changes at St. George's Hospital.

A SPECIAL meeting of the governors of St. George's Hospital was held on December 9th for the purpose of considering some important changes in the management of the institution. Hitherto the offices of secretary and superintendent have been combined, and for some time this arrangement has been found to be inconvenient. The whole matter has been thrashed out by the committee, and a scheme was submitted to the court of governors. It was decided to appoint a medical superintendent who should reside in the hospital, and a secretary who should be allowed to live at his private house. Under the old rules the office of secretary was open only to bachelors and members of the Church of England, but the governors have now taken a broader view, and the official may be a married man and is not required to undergo a religious test. The meeting was presided over by Mr. A. William West, the treasurer, and amongst the forty governors who attended were Lord Arthur Hill, Captain C. B. Balfour, Sir William Bennett, the Hon. Dudley Fortescue, the Hon. Sydney Carr Glyn, Dr. T. Ridge Jones, and the Rev. A. G. Locke.

The Irish University Question.

AT a full meeting of the staff of Trinity College, Dublin, summoned by the Provost on Saturday, the following was passed unanimously:—

"That, fully realising the importance of a settlement of the University question, this meeting of the staff of Trinity College and members of the Academic Council think it undesirable to express any opinion on proposals which have not yet been formulated as a Government Bill, but they think it right to re-affirm the declaration contained in the statement issued by the Executive Committee of the Dublin University Defence Committee in March, 1907—viz., should the Government determine to introduce a measure which, while leaving to Trinity College and the University of Dublin their present independent and unsectarian character, would at the same time be acceptable to our Roman Catholic fellow-countrymen, it would be a matter of supreme satisfaction to all who are interested in higher education in Ireland, and who desire a final settlement of the whole question. We, for our part, have confined ourselves to working out our solution. We have not thought it our duty either to advocate or oppose any scheme for the satisfaction of the reasonable claims of Roman Catholics which does not interfere with our own development along undenominational lines."

Royal Academy of Medicine in Ireland.

AT a meeting of the Obstetrical Section of the Royal Academy of Medicine, held on Friday last, the following resolution was unanimously adopted:—

"That the Obstetrical Section of the Royal Academy of Medicine regard the recommendations of the General Medical Council regarding obstetrics teaching as in many cases a very great advance on the present conditions. The section, however, considers that the suggested alterations of the period of attendances on a Maternity Hospital from six months to three months would not be advisable or practicable. The section considers that instead of reducing the attendances, the licensing bodies should adopt such regulations as will insure the regular attendances of the students at the clinical teaching of the hospitals. With regard to the adoption of a practical examination in midwifery and gynæcology, the sections consider that such a step is most desirable, and urge its members to aid it by all means in their power."

PASS LISTS.

Royal College of Surgeons of England.

AT an ordinary meeting of the Council of the College held on the 12th inst., the following members of the College, having passed the required examinations and conformed to the bye-laws, were admitted Fellows of the College:—

Hugh Ainsworth, captain, I.M.S., M.B., Ch.B.Vict.; William Appleyard, M.B., B.S.Lond.; E. W. Bain, M.B., B.S.; W. E. Brierley, M.B., Ch.B.Vict.; Hubert Chitty, M.B., B.S.; Colin Clarke, M.B., L.R.C.P.Lond.; A. J. Couzens, L.R.C.P.Lond.; Millais Culpin, M.B., B.S.; W. E. Fisher, L.R.C.P. Lond.; J. G. French, M.B., B.S.; H. T. Gray, M.A., B.C., Cantab.; Henry Hardwick-Smith, M.B.Cantab., L.R.C.P.Lond.; S. C. Hayman, L.R.C.P.Lond.; Reginald Jamison, M.A., M.B., B.Ch.Oxon.; Thomas McPherson, M.D.McGill; R. D. Maxwell, M.D.; Edwin Maynard, L.R.C.P., D.P.H.Lond.; W. S. V. Stock, M.B., B.S.; Philip Talbot, M.B., Ch.B.Vict.

The following candidates, not being members of the College, were also admitted Fellows:—L. R. Braithwaite, M.B., Ch.B.Vict.; K. McKenzie Duncan, M.B., Ch.B.Glasg.; Edward Gillespie, M.B., Ch.B.Glasg.; J. L. Falconer, M.B., Ch.B.Vict.; David Ligat, M.B., C.M.Glasg., D.P.H.Vict.; H. F. Shorney, M.D., B.S.Melb.

The following is a list of new licentiates in dental surgery:—Stanley Bellman, R. D. Bennett, L. W. Biscombe, John Button, J. W. Doherty, W. A. Dredge, William Drew, R. Dent, H. G. Dumayne, J. G. Fernie, E. E. Fletcher, A. W. Gant, Percy Gee, R. J. Gibbings, J. K. Hargreaves, Ernest Harrison, A. F. Hochapfel, Graham Hunt, C. E. James, T. N. Jeffries, H. E. Jones, A. T. Knight, Isaac Levy, Oswald McGowan, J. F. Maguire, L. T. B. Matthews, Federico Montuschi, F. R. H. Myers, C. R. M. Peaty, C. G. Plumley, P. J. Proud, Lewis Richter, E. G. Robertson, C. R. Rudolf, F. H. Salter, R. A. Scott, H. V. Sharp, Sydney Shovelton, A. W. Smith, I. S. Spain, W. M. Swan, A. C. Tippett, A. I. Ward, R. G. White, and R. T. Wood.

Diplomas of membership of the College were issued to John Lewis, Univ. Coll. Hosp., and to J. L. Todd, McGill Univ., Canada.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

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Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Saccharine.—There is some evidence that diabetes is a microbic disease in some cases, though at present the theory does not fit all the facts of the case. The idea that it is so obtains a certain amount of confirmation from the fact that it is endemic in certain parts of Bengal, and not in the surrounding districts and provinces.

Mr. R. Wright.—We have no knowledge of a sanatorium that accepts patients at the very moderate fee mentioned. There are, of course, charitable institutions in which patients are received without charge, on the recommendation of subscribers, but we take it this is not what you are seeking. There is a "Handy Reference List" published at 6d. by Pullman and Sons, Limited, Thayer Street, London, giving a complete list of sanatoria with their charges, which we would advise you to consult.

Edinburgh Student.—We know of no work on anatomy that answers your requirements so fully as Professor Buchanan's recent "Manual of Anatomy" (University Series of Text-Books), as it is systematic and practical, and includes embryology. The illustrations are in colours, and will be found very helpful.

PERSONAL PARAGRAPHING.

The *Evening Standard* of December 7th, contained the following paragraph:—"One of the King's Physicians Extraordinary, a Knight of Grace of St. John of Jerusalem, Sir Joseph Fayrer, reached the venerable age of eighty-three, and in the mild climate of Falmouth, where he is passing his declining years, he still devotes much of his time to literature and the fine arts. Apart from his lifelong practice as a surgeon, and his long service in India, including the Mutiny, the professorship of the Medical College of Calcutta, and the presidency of the Medical Board of the India Office, he has written many books, both professional and otherwise. Among the better known of the latter class are 'With the Prince in India,' 'The Life of Sir R. Martin, C.B.,' and 'Recollections of My Life.'"

May the memory of the good deeds of all of us survive as vividly!

D. S.—We are much obliged for your kind compliments. The incidents, regrettable enough in themselves, are being worked for all they are worth to throw odium on the profession, and we feel it our duty to expose such sorry tactics.

L. M.—There is no valid objection to the course you propose, and you are justified in taking it without reference to anyone, as you have been so badly treated. It would be better, however, to take a philosophical view of the matter, and call on your fellow practitioner to make a personal explanation of your motives in doing so. Then no blame could possibly be imputed to you.

N. R. G.—1. Yes. We agree entirely. 2. Yes, but with the reservation you mention. 3. No. It does not follow, and your ingenious theory does not hold water.

Promotion.—The Indian Medical Service offers excellent opportunities in the direction referred to. The next examination for 16 Commissions in the Service will be held in London on Tuesday the 28th. January, 1908, and the four following days. Particulars regarding pay. promotion, &c., in the Service, and the necessary forms of application. can be obtained from the Military Secretary, India Office, London. You will find fuller particulars on referring to our advertisment columns.

Meetings of the Societies, Lectures, &c.

Wednesday, December 18th.

Royal Microscopical Society (20, Hanover Square, W.).—8 p.m.: Mr. E. Large: Exhibition of Selenite Specimens showing interesting features due to Twinning. Papers:—Mr. J. Murray: Some African Rotifers.—Mr. E. M. Nelson: (1) Gregory and Wright's Microscope; (2) A Correction for a Spectroscope.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. J. Cantlie: Clinique (Surgical).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Cliniques:—2.30 p.m.: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Thursday, December 19th.

Child-Study Society (Parkes Museum, Margaret Street, W.).—8 p.m.: Lecture: Miss A. Ravenhill: Some Results of an Investigation into Hours of Sleep amongst Elementary School Children in England.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m. Gynæcological Operations (Dr. Giles).—Cliniques:—Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 Throat Operations (Mr. Carson).

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Hutchinson: Some Diseases of the Newly Born.

Central Midwives' Board (Caxton House, Westminster) at 2.45 p.m.

Friday, December 20th.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique:—Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Appointments.

Beattie, Thomas, M.D.Durh., M.R.C.P.Lond., Honorary Physician to the Royal Victoria Infirmary, Newcastle-upon-Tyne.

Bolam, Robert A., M.D., B.S.Durh., M.R.C.P.Lond., Honorary Physician to the Skin Department, Royal Victoria Infirmary, Newcastle-upon-Tyne.

Cassidy, M. A., M.B., B.C.Cantab., M.R.C.P.Lond M.R.C.S.Eng., Resident Assistant Physician at St. Thomas's Hospital, London.

Codd, J. Alfred, M.D., B.Sc.Lond., Physician to the Wolverhampton and Staffordshire General Hospital.

Gowring, B. W. N., M.R.C.S., Honorary Surgeon to the Dorset County Hospital.

Smith, J. B., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Hertford District of the county of Hertford.

Timms, Alec Boswell, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Visiting Medical Officer to the Cardiff Workhouse.

Vise, J. N. B., L.R.C.P.Lond., M.R.C.S., Certifying Surgeon under the Factory and Workshop Act for the Axminster District of the county of Devon.

Vacancies.

Kent County Asylum, Maidstone.—Fourth Assistant Medical Officer. Salary, £175 per annum, with furnished quarters, attendance, coals, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Casualty Medical Officer. Salary, £200 per annum with lunch. Applications to the Secretary. (See Advert.)

Corporation of Manchester.—Assistant to the Medical Officer of Health. Salary, £200 per annum. Applications to the Chairman of the Sanitary Committee, Public Health Office, Town Hall, Manchester.

Suffolk District Asylum, Melton.—Second Assistant Medical Officer. Salary, £160 per annum, with board, furnished apartments, attendance, and laundry. Applications to the Medical Superintendent.

Bristol General Hospital.—Senior House Surgeon. Salary, £120 per annum, with board, residence, etc. Applications to the Secretary.

Liverpool Hospital for Consumption.—Resident Medical Officer for the Sanatorium at Kingswood, Delamere Forest. Salary, £400 per annum, with a house (unfurnished). Applications to Alfred Shawfield, 77a, Lord Street, Liverpool.

Cardiff Union.—Assistant Medical Officer. Salary, £130 per annum, with rations, apartments, attendance, and washing. Applications to Arthur J. Harris, Clerk, Union Offices, Queen's Chambers, Cardiff.

Births.

Riley.—On Dec. 12th, at 3, Culverden Gardens, Tunbridge Wells, the wife of Francis Riley, M.D., B.S., F.R.C.S., of a son.

Marriages.

Berry—Logan.—On Dec. 14th, at the Wesleyan Church, Hammersmith, Sidney M. Berry, M.A., younger son of the late Dr. Charles Berry, of Wolverhampton, to Helen, eldest daughter of J. M. Logan, of Bedford Park, Chiswick, W.

Deaths.

Cary.—On Dec. 10th, at 71, Thorney Hedge Road, Gunnersbury, Middlesex, Tristram Cary, M.D., third son of the Rev. Anthony Cary, Rector of Glendermott, Londonderry.

Falls.—On Dec. 11th, at Curraghmore, Bournemouth, Alicia, Mary, widow of William Stewart Falls, M.D.

Spong.—On Dec. 13th, at Lynsted, Beckenham, William Spong M.R.C.S., L.R.C.P., eldest son of the late William Nash Spong, of Faversham, Kent, aged 52.

Williams.—On Dec. 13th, at Holt Street House, Wrexham, Joseph Llewelyn Williams, M.B., aged 63.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXV. WEDNESDAY, DEC. 25, 1907. No. 26.

NOTES AND COMMENTS.

Roll of Merit.

THE distinctions awarded by the State for medical and scientific eminence are few and niggardly, and we should like to see them greatly enhanced. But, while waiting for that *desideratum*, we may content ourselves with a new Order of Merit, not the one recently conferred on Miss Florence Nightingale, but that created by the *Vaccination Inquirer* for districts and unions having between 40 and 50 per cent. of the children born in them returned as unvaccinated. This strange honour was instituted in 1903, and thirty-three names were inscribed on the roll; in 1904, the last year presumably for which complete returns have been issued, the number is thirty-six. Three London Unions, Mile End Old Town, Poplar, and Bethnal Green figure in it, together with two registration counties, Northampton and Bedford, and fifteen provincial unions. The highest "honour" belongs to Hinckley, which has a percentage of unvaccinated births amounting to 48.4; while the wooden spoon belongs to Leighton Buzzard, with 40.2. The *Vaccination Inquirer*, which seems to make very little inquiry about vaccination, and to express a great deal of dogmatism about it, naturally rejoices at the increasing list of the claimants to its distinctions, but bewails the loss of three old recipients which have fallen away from the faith, whether as the result of a small-pox outbreak or not we do not know. We do not gather if any token of the "honour" is bestowed upon the successful ones, or whether the barren distinction of enrolment is all the consolation achieved. If it did not savour of idolatry one should be induced to suggest that a golden calf might be awarded to the union having the highest "percentage not cowpoxed": such an emblem might stimulate noble emulation and serve as a totem for the anti-vaccination tribe. But perhaps a model of a lunatic asylum might be more appreciated.

"Rice" Treatment.

OUR contemporary, *John Bull*, for December 14th, contains the following notice:—"Senile (Bath).—We are not medical experts, and cannot take upon ourselves the responsibility of advising the 'Rice' or any other treatment for rupture." The first thought that occurs is, *O si sic omnia*. When the veriest rags of papers do not hesitate to give medical advice and to publish lying statements about doctors' errors, it is something of a relief that one paper at least should proclaim its disqualification to give expert advice on technical subjects. But we confess, if we may humbly assume the title of expert, that we are as ignorant of the "rice" treatment of rupture as our contemporary. Indeed, beyond connecting the word with a theory of beri-beri and a simile for cholera stools, "rice" suggests but little to us in medicine, and how it should be used in the treatment of hernia is a "poser." The rupture quack is always somewhat of a mystery; how he manages to persuade his victims to do anything except wear a truss and yet imagine benefit is difficult to conceive. Still more so is that the seniles of Bath should regard *John Bull* as an authority on the disease, except on the well-recognised principle that there are many people who think all editors are Admirable Crichtons and Dr. Murrays rolled into one.

Limericks and Insanity.

THE limerick craze has been a godsend to the papers which have opened their columns to that intellectual form of entertainment, for the numbers of would-be prize-winners who have bought their issues, not for their literary charm but for the limerick coupon, must have had a prodigious effect on their circulation. It is sad to record that a poor fellow, the tramp-master of the Cheltenham Workhouse, should have been literally so "crazed" by these competitions as to take his own life. At the inquest it was proved that he had hanged himself after unsuccessfully attempting to cut his throat with a razor, and medical evidence showed that he was much excited over limerick competitions, and was greatly disappointed that he had not gained a prize. The Coroner was shown between fifty or sixty counterfoils of sixpenny postal-orders, and it was said that he had spent a large amount of money in going in for competitions. Moreover, many "last lines" were produced in Court. The victim had sent a letter, from which it was evident he was much annoyed at his non-success, to each of the papers in which he had competed. An extract from this ran: "I have read the lines to which prizes have been awarded in your limerick contests for some weeks past, and if there is no favouritism or fraud in the contests, then it is time the adjudicators consulted a medical man and had their heads examined; most of the winning lines have no merit whatever." Although the jury returned a verdict of "suicide whilst temporarily insane," we are tempted to doubt the insanity of a man who had diagnosed the situation with such acumen, and given such excellent advice to those concerned.

Notification Errors.

IN the South-West London Police Court, Dr. S. A. Mugford, of Balham, was recently summoned by the Wandsworth Borough Council for failing to notify to Dr. Caldwell Smith, Medical Officer of Health for Wandsworth, a case of infectious disease. The defendant pointed out that he tried to do everything possible to acquaint the medical officer. He had telephoned to the Public Health Department of the Borough Council, and received a message to say that Dr. Caldwell Smith was absent, and that there was no one to receive the official notification. He thereupon communicated with the Metropolitan Asylums Board and had the patient removed. When asked why he did not send the notification by post, he said he wanted the patient removed immediately, and if he had posted the intimation, a day's delay in the removal would have taken place. The caretaker at the Borough Council offices, a curious official to use for the purpose, said that he had not received the intimation, but Dr. Mugford was quite positive about the message having been received. The magistrate said that it was more an act of inadvertence than anything else that Dr. Mugford had not actually sent the formal certificate, and if it was the case that notifications could not be received at the Town Hall at any period of the day, there must be a screw loose in the department somewhere, and the sooner it was remedied the better. He imposed a penalty of one shilling only, and sharply declined to allow the prosecution their costs. We presume that, a technical error having been committed, it was impossible not to convict, though that is by no means certain, but the smallness of the penalty and the refusal of costs sufficiently indicate the magistrate's opinion.

And their Results.

WE do not hesitate to characterise the use of the Police Court for the purpose of getting a penalty out of a medical practitioner who has notified a case in every way except by using a certain form as not only a blunder, but a distortion of the legal process. And when to that is added the fact that the administration of a health department of a large London borough is so conducted that urgent notifications cannot be received and acted upon during the daytime, it strikes us that justice demands that the position of defendant and prosecutor should be reversed. The notification of infectious diseases is not an end, but a means to an end, and if the power to use the legal means provided by the Act is tyranically and arbitrarily used, not only is public health administration brought into proper contempt, but it fails in its most important function, that of maintaining proper relations with the real health guardians of the people, namely, the medical practitioners. We lately had occasion to comment on the protest made by the Manchester Medical Guild against the action of the health department of that city in invading the privacy of patients' houses and bedrooms in defiance of their own and their doctors' wishes. We deplore the tendency that shows itself in various quarters for some health departments, now that they have come into being by medical advice and support, to assume towards both the people and the medical profession these bureaucratic methods which are as ill-advised as they are un-English. Unless health authorities work with the community in a sympathetic and considerate manner, their power will properly be curtailed, and the advance of practical hygiène delayed for years. The Notification of Births Act puts a new and most powerful weapon in their hands, and if it be employed in any but the gentlest and most beneficent fashion, it will utterly defeat its own end.

A Happy Hunting-Ground.

THERE is a happy land for doctors, but unfortunately it is situated at some distance. A correspondent of the *Glasgow Evening Times*, however, draws attention to it, and his description makes the mouth of the British medical struggler water. The land of delights is New Zealand, whose natural charms are sufficiently well known not to need description here. But over and above its charming climate, its beautiful scenery, and its virile population, New Zealand, says this gentleman, quoting another writer, could accommodate five hundred more doctors, and supply them with a *clear* income of £400 to £500 a year. In the large towns incomes running up to £2,000 a year are not out of the way, but the ordinary country practitioner is wanted, not in single spies, but in half a battalion, and the Dominion lies at his feet. Says one writer: "This may be a help to many who are wondering when they will find a practice. Let them make straight for New Zealand and get out into the country and have a good time, instead of a wearisome wait on 'dead men's shoes' in our home cities." The prospect is so alluring as to tempt us to fling down the pen and seek the shipping agent; but we must warn our readers who are longing to be off that vaccination is not popular in New Zealand, and that "doctors who depend on this operation are looked on somewhat suspiciously." Alas! all amber contains its fly.

LEADING ARTICLES.

MIDWIVES IN DEFAULT.

THE Central Midwives' Board has, thus early in its career, been called upon freely to exercise its penal powers. A number of licensed midwives have been struck off the register, and it is a matter of interest, as well as of importance, to the medical profession, to realise the conditions under which the particular offences in question were committed. There is, of course, something to be said on the score of the formation of a new register in which many worthless persons must necessarily be included, and from which it is obvious they will, in the nature of things, be rapidly excised. Some of the offenders show that they treat the fact of being licensed under the Act with absolute levity and contempt, inasmuch as they have not even satisfied the preliminary condition which demands equipment of each midwife with various drugs and appliances. Without such provision the most elementary skilled midwifery could not be conducted, for example, in the administration of antiseptic douches, the taking of temperatures, and catheterisation. That is a serious matter enough, chiefly because it shows the absolute indifference of a certain number of women to the responsibilities undertaken by them on registration. A similar recklessness led to several names being struck off for failing to call in a medical man in cases of retained placenta, ruptured perineum, and puerperal fever. This is precisely one of the things that it was predicted would take place were a hybrid class of registered women practising in one branch of medical work under the ægis of registration. This attitude was exemplified in an exaggerated degree in the case, to which we made allusion last week, of a midwife who prescribed quinine and iron to one of her clients. Indeed, one can readily imagine how hard it would be for a half-educated woman to grasp the fact that, although she might administer any one of the whole family of purgatives, solid or liquid, in any form or any combination, with the authorisation of the State that granted her a licence, nevertheless she might not prescribe any other drug in any other way. In this difficulty of drawing the line lies the great, and to many medical minds, the insuperable objection to the whole Act. The woman who is authorised to attend the simple confinement will find little difficulty in convincing herself that she is competent to deal with the difficult cases. It is hardly possible, on any other assumption, to explain the numerous cases in which licensed midwives have neglected to summon medical aid. The greatest and most appalling defect revealed in the whole of these charges, however, is the fact that women attending puerperal fever cases either failed to report the case, or neglected to use disinfectants and call in a medical man, or went on attending other cases, and thus spread this terrible infection. The fact of the matter is that it takes a long and careful medical training to recognise a morbid condition of the kind, and it is absolutely useless to expect the average ill-educated midwife to recognise the fact that her patient has been invaded by a deadly infection. Some of the women subjected to the disrupture of the Board had not even furnished themselves with the thermometer essential to the formation of an early diagnosis of the malady. On logical grounds, the man in the street will one day probably be forced to the conclusion, long since arrived at by the general practitioners of the United Kingdom, namely, that the conduct of labours should be left in the hands of qualified medical men and women, and that there is absolutely no need to set aside a special class of registered women for that particular work, any more than it is necessary to certify nurses to attend, say, pneumonia, broken bones, or skin diseases. Most medical men will probably agree that before receiving any recognition as a competent midwife a woman should have a prolonged and careful nursing education. Further developments under the Midwives Act deserve to be watched closely, as they may in no distant future demand great attention at the hands of the legislature when called upon to frame a fresh Medical Act.

THE FEEDING OF SCHOOL CHILDREN.

THE progress of Society towards the attainment of its ideals is seldom rapid, and perhaps it is well in some cases that advances should be made chiefly in response to well-ascertained shortcomings. Otherwise, so much is man a creature of impulse, the community might find itself kept in a more or less continual commotion by the pursuit of impossible ideals. In the case of public education there is still a great deal to be learnt in our treatment of school-children, apart from the altogether vexed questions of what we ought to teach them and the best way of imparting knowledge. For all that, the State has within the past few years made some noteworthy advances as regards the children who are educated at the expense of the public. Roused by the cry of national degeneracy, a great deal of attention has been recently paid to the physical conditions and requirements of the people. One of the indirect benefits of that awakened interest has been to focus a large amount of enquiry upon the schools. A general demand for the proper sanitary control of the educational environment has been followed by various salutary measures, and has culminated in the Act which for the first time institutes the systematic medical examination of scholars. The absolute necessity of such a provision is well illustrated by the increase for many years past of diphtheria, which is essentially a school disease. Then, again, who can doubt that the scarlatina problem, which is the despair of sanatarians, is largely influenced by the conditions of school-life? There is little need to labour the point, however, for it stands to reason that the bringing together of children in large numbers at an age when they are peculiarly open to attack by infectious disease is to multiply the already complex problem presented to the medical officer of health in the attempt to control the great zymotic maladies. Almost at the end of the series of new faiths came the sudden recognition of the fact that it is useless to teach starving children, and that the backbone of the nation might be strengthened to an incalculable degree by providing food for the State children whose parents were unable to fulfil that necessary duty. The outcome of this new gospel was the Provision of Meals Act, whereby local authorities were empowered to feed school-children at the public charge. This statutory permission was speedily taken advantage of in various large centres of population, among which may be mentioned Brighton, Birmingham, Bristol, and Manchester. Curiously enough, the greatest city, not only in the kingdom but also in the world, declined to use their powers under the Act. The consequences of this short-sighted policy are not far to seek. Every ill-fed child of the poorer classes of the community must inevitably become, sooner or later, a charge upon the State. So that Londoners, who to-day are saved a small direct tax to feed these foodless scholars, will in the long-run have to pay many times that amount to hospitals, workhouses, prisons, and Poor-law infirmaries. We are not concerned with the politics of the London or any other County Council. At the same time, as a medical journal, we cannot help feeling the deepest interest and anxiety when any well-conceived plan for advancing the collective stability of the public health is permitted to go astray by the apathy or short-sightedness of local administrations. It needs little argument to show that the refusal to make good so grave a defect in our social system as the existence of many thousands of children in a state of chronic semi-starvation must be to undermine the future of our race. No class of the community is in a better position than the medical profession to judge of the ravages worked by shortage of food amongst the poor, for they are brought into close contact with the facts themselves in all their phases. On the score of public health, and of the radical necessity of fostering the vitality of the rising generation, not to mention considerations of political economy and of ordinary humanity, we trust that wiser and better views will utimately prevail on this point in the London County Council, and that other local authorities in all parts of the kingdom will follow them in adopting this salutary Act. It is a weak alternative to draw upon the resources of private charity to replace what should, in our opinion, clearly be the recognition by public citizenship of an elementary duty. The springs of private benevolence are already seriously drained in attempting to satisfy the needs of the medical charities, which will suffer proportionately if donations be diverted to the feeding of the school-children by channels that must at their best be somewhat intermittent and altogether uncertain.

CURRENT TOPICS.

A Workhouse Scandal.

AN inquiry into the death, on December 4th, of a recent inmate of Wandsworth Infirmary, is being made by the Westminster Coroner under unusual circumstances. As the inquiry, which involves an explanation, is still incomplete, we refrain from comment upon the case. There is one point, however, to which the attention of all Poor Law medical officers should be directed, namely, the discharge of responsible nursing, dispensing, and other more or less directly medical services in the midst of a mass of other duties. One witness, who is alleged to have made some lapse, produced the following list of duties :—

(1) Assist with coaling and removal of ashes and poultice tins. (2) To obey all orders of the medical officers and stewards. (3) To bathe all male patients on admission, unless countermanded by the medical officer. (4) To search the clothes of the male patients when admitted, and place them in a numbered bag and rack in the clothing-store; make list of all articles, and put clothes away thoroughly dry. (5) Immediately hand to the steward all money, documents, or other valuables found on patients. (6) Bake carefully and thoroughly all foul clothes, underclothing to be taken to the laundry, and the whole afterwards placed in the clothing-stores. (7) To be responsible for the good order of the patients' clothing-store. (8) To assist in carrying patients or articles of furniture to and from the wards. (9) To take to the master all the clothes of deceased male patients, entering a list of the articles in a book. (10) To bake all foul bedding, clothes, etc., from the wards with great care, and disinfect any room when desired. (11) To assist every day with the patients' dinner, and convey milk to such parts of the infirmary as directed. (12) To collect the bottles for the dispensary, and deliver them to the nurses when the medicines are made up. (13) To wash the bottles for the dispenser. (14) To keep in good order the bottle-room, dispensary, store, drug-room, and the two bath-rooms of the male receiving ward. (15) To sweep daily and wash down on Saturdays, or more often if required, the disinfecting chamber, the yard adjoining the mortuary, and the steps leading to the subway. Also to take weekly turn in rotation with the other porters in the washing of the new bath-room, lavatory, etc. (16) To attend to the hall when required.

For this multifarious service the Guardians paid the munificent sum of £1 per week.

Inaccurate Prescriptions.

THE vital importance of the purity of accuracy of the ingredients of the physic compounded by chemists is self-obvious. In places where the matter has been put to the test startling results have been in various cases forthcoming. Only last week a London chemist was fined £5, or in default one month's imprisonment. The defendant did not appear, but he runs a good chance of the more serious punishment should he offend again in a similar way. At last the modern tendency of magistrates appears to incline towards greater severity. It would be hard to imagine a meaner or more injurious offence than that of substituting one preparation for another ordered by a medical man, no matter whether the motive be parsimony, convenience, or a desire to save time. As the gentleman who appeared for the City solicitor remarked, the matter was most serious because medical men depended upon accuracy in the making up of prescriptions, and Dr. Teed, the public analyst, had told them in his report that many drugs had been considered worthless, whereas in reality they had never been tried. Since April last 23 City prescriptions have been analysed, and no fewer than twelve of them were found to have been inaccurately dispensed. The state of trade morality thus disclosed reflects most undesirably on the main body of a class of men whom the public have learnt to regard with entire confidence.

An Alternative Drink for Alcohol.

A CORRESPONDENCE has been recently evoked in the columns of a London newspaper by a writer who advocated an alternative drink containing tincture of capsicum to allay the craving for alcohol. This caught the eye of a scientific gentleman, who promptly pointed out that tinctures, being made with spirit, to prescribe them in such cases was simply adding fuel to fire. This statement brought a number of medical men into the fray. One side maintained that tinctures could be made without alcohol. Strictly speaking, we fail to see how a non-alcoholic extract could consistently be called a "tincture," although most medical men are aware that it is possible to substitute for nearly all pharmacopœial tinctures a cheaper non-alcoholic preparation which is usually fairly equivalent from a therapeutic point of view. In the case of capsicum the extract, as a matter of fact, is much stronger than the tincture. The other class of medical critics emphasise the absurdity of objecting to the presence of such a fractionally minute dose of alcohol as that contained in a few drops of tincture of capsicum. Were the objection to alcohol pushed to the absurd degree of excluding all alcoholic preparations of drugs, the practice of physic would be handicapped thereby in a quite unnecessary manner. Incidentally, the interest shown in the discussion under notice illustrates the deeply-rooted belief of the vulgar in the possibility of specific drug cures, and, so to speak, antidotes for alcoholism. It would be difficult to produce an illustration of a more widely diffused popular error than the one upon which the fortunes of the drink "cure" is founded.

Incriminated Kippers.

A RECENT case in the High Courts opens up a novel and somewhat interesting point in the annals of ptomaine poisoning. It concerned an action for breach of warranty on the sale of an article of human food, namely, kippers. The defendants, in reply, denied the warranty, and alleged that all kippers supplied by them were sound and wholesome. The plaintiff one afternoon went to the defendant's restaurant and there partook of tea, bread and butter, and kippers. He noticed, he said in evidence, that part of the fish had a musty smell and did not eat any more. On the following morning he was seized with a violent attack of ptomaine poisoning, from which he ultimately recovered. His medical attendant stated that he had seen a similar case in his own household from eating an unsound kipper. Such cases, however, must be, we imagine, extremely rare. There is the cogent fact adduced on behalf of the defence by Dr. Alfred Stokes, Public Analyst for Paddington, who testified that poisoning from kipper was unlikely, namely, that the internal organs of the herring were removed in the course of preparation, which further involved salting, smoking, and drying—to say nothing of the purification by cooking. The jury had little difficulty in finding a verdict in favour of defendants.

A Public Medical Service.

The medical men of Birmingham have inaugurated an important scheme for the service of persons who are unable to pay ordinary fees. Any practitioner of twelve months' standing is qualified to join, provided he does not attend any sick clubs. Branch institutions are to be formed as necessary, and the medical officers are to be chosen from members. Each applicant has to be passed by one of the staff, who is responsible for fitness. A fee of at least twopence per week is to be paid by each person joining the organisation as a patient, and members are to be remunerated by a division of profits at stated intervals. Each patient is entitled to choose his or her medical attendant. The medical benefits do not cover confinements, consultations, disease arising from misconduct, serious injuries, dentistry, surgical operations, anæsthetics, and the supply of bottles or appliances. At the same time, it is proposed to make certain definite charges for night visits and extra services of various kinds. This appears to be a well-thought-out plan for facing the competition of hospitals, clubs, and other agencies that divert the poor from their proper medical attendants, namely, the general practitioner. The future of this energetic organisation deserves to be carefully watched by the medical profession generally. It is not the first time that the medical men of Birmingham have shown themselves capable of firm action in the attempt to defend their own interests.

The Manchester Epileptic Colony.

Manchester can boast of the finest epileptic colony in the world, and is making great efforts to seriously combat the disease. The medical report of the colony shows that during the past year, with the average number of colonists standing at 171, the total number of fits recorded was 29,444. These were unequally divided among the colonists; some had none, others had very many. One woman is reported to have had 2,814 in twenty consecutive days, with a maximum for twenty-four hours of 239. Another woman is said to have had 609 heavy major attacks in eight consecutive days. Both these patients are now going about; one of them has been free from fits since May. Another girl had 1,743 in February, 725 in June, and 565 in August. Such cases must obviously make great demands on the part of the staff. The epileptic colony movement is one that deserves the hearty support of philanthropic persons.

The "Brown Dog" Disturbances.

In our last issue we referred to some of the newspaper comments on the recent "brown dog" disturbances, remarking on the curious antipathy to the medical profession which they revealed. We are glad to see that some of the more respectable weeklies have shown more fairness, and have drawn attention to a point in connection with the disturbances which had escaped general notice. This is the refusal of the police authorities to allow the medical students the privilege accorded to all other sections of the public, of holding meetings in Trafalgar Square, and of walking in procession through the streets. So far as we can learn, there was no special disorder attached at first to the meetings of students, and we fail altogether to understand why they should have been specially selected for bludgeoning by the police. The disorder, indeed, seems to have been enormously increased, if not created, by the injudicious interference of the police authorities. The object for which the students met may have been a foolish one or a wise one, but it was no worse than the hundred-and-one other objects to which meetings in Trafalgar Square—undisturbed by the police—are devoted. It is hardly the function of the authorities to act as censors of the purposes of meetings in public places, and, as we suggested last week, Russian methods are out of place in London.

Copper in Spinach.

Two fines of £5 and £4, with costs, have recently been imposed in London police courts for selling preserved spinach in tins. Analysis showed in one case 4.70 grains of copper sulphate, and in the other 3.29 grains per pound. Medical evidence showed that the proportion of the copper salt mentioned would be injurious to health. Half a pound of such spinach would in some cases cause symptoms of irritant poisoning. The defendant stated that tinned spinach was used in every restaurant in London, and he claimed that the prosecution should be turned to the wholesale manufacturer from whom the tins came. Some years since a similar exposure took place in the case of preserved peas.

PERSONAL.

Dr. Deane Sweeting has been reappointed an Examiner in State Medicine at Cambridge University.

Dr. C. Guerin and Professor A. Calmette have been awarded the Louis Boggio prize for their researches on tuberculosis.

The King of Spain has conferred upon Dr. A. J. Rice Oxley, Physician-in-Ordinary to Princess Henry of Battenberg, the Order of Isabella the Catholic.

Under the will of Mrs. Fanny Peach, the Nottingham General Hospital has benefited to the amount of £1,000, and the Brompton Cancer Hospital to that of £500.

Among new members of the Council of the Metropolitan Hospital Sunday Fund are Sir James Reid, K.C.B., Sir Thomas Smith, K.C.V.O., and Mr. Thomas Wakley.

In our last issue we stated that Dr. Arthur J. Hall had been appointed Lecturer on Practical Medicine, University of Sheffield. In so doing we referred to Dr. Hall as Physician to the Sheffield Royal Infirmary. This should have been the Sheffield Royal Hospital.

The Liverpool medical students' annual dinner, which took place on December 14th, with Professor Rushton Parker as chairman, and Dr. John Owen as Vice-Chairman, was made the opportunity for presenting Professor Parker with his portrait in oils.

Among the new members of the General Council of King Edward's Hospital Fund for London are Lord Rosebery, the Speaker of the House of Commons, the President of the Local Government Board, Professor Osler, and Dr. Edwin Freshfield.

By the will of the late Mr. Thomas Berry, the Clinical Hospital for Women and Children, Manchester; the Altrincham Provident Dispensary and Hospital, the Salford Royal Hospital, and the Ancoats Hospital and Dispensary receive £1,000 each.

The honorary surgical staff and committee of the Margate Cottage Hospital have presented Mr. William Knight Treves, F.R.C.S., with an illuminated address, in appreciation of his thirty years' service.

A CLINICAL LECTURE
ON
THE SERUM TREATMENT OF TYPHOID FEVER
(ANTITYPHOID OPSONISATION).

By DR. CHANTEMESSE,

Professeur Agrege of the Faculty of Medicine of Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

DURING the last six years (April, 1901, to July, 1907) 5,621 cases of typhoid were admitted to the Paris hospitals with a mortality equivalent to 17 per cent. Since then a thousand typhoid patients have been treated in my fever wards with a mortality of only 4.3 per cent. My treatment comprises cold baths (24° to 30° C.), *plus* the injection of antityphoid serum.

In 1906, Professor Brunon, of Rouen, and Dr. Josais, of Paris, brought to the notice of the Academy of Medicine an improvement in the typhoid mortality under the serum treatment, this having fallen from between 10 and 12 per cent. to from 3 to 4 per cent. During the same period the mortality at the Val-de-Grace Hospital remained at 10.6 per cent.

Under the influence of the antityphoid serum the course of the disease is invariably modified in much the same manner. The evolution of the disease is sharply divided into two periods, the first being the stage of reaction following the injection, the second the process of defervescence. The first stage lasts from a few hours to several days, during which the temperature falls but slightly or not at all—indeed, it may even be a shade higher; then suddenly it goes down, the baths are required less frequently, and a steady decline sets in. The constitutional symptoms accord with the state of the temperature, and the patient does not feel any benefit until the onset of the second stage. When this sets in the patient may have hyper-pyrexia, necessitating several baths daily, but he feels better, the appetite returns, and he secretes plenty of urine. At this juncture there supervenes a very curious—indeed, characteristic—sign in typhoid fever, modified by the serum treatment—viz., a striking change in the vaso-motor system.

Every physician is familiar with the typical facies of the typhoid patient, in whom, in spite of the high central temperature, the tip of the nose, the hands and the feet are cold, and the nails are cyanotic. In patients treated with the serum, at the expiration of the stage of reaction the facies markedly improved. Colour returns to the cheeks, the stupor is modified, the hands lose their pallor and are warm, and the nails have a rosy hue. This improvement in the peripheral circulation persists throughout, and accounts for the wonderful improvement in the appearance of patients thus treated.

The improvement is the more marked the earlier the serum has been injected after the onset of the disease—that is to say, at a period before the organic resistance has been broken down, and can therefore react energetically to the treatment. I have not lost a single patient during the last six years in my fever service in whom the injection has been made within the first seven days of the disease.

When the serum treatment is resorted to late—and by late is meant more the gravity of the damage already done than the mere number of days—the results are less rapidly favourable. The serum cannot bring about the disappearance of the nervous lesions, nor prevent the necrotic intestinal lesions when already present.

The blood pressure goes up within a few hours of the injection, and may reach between 12 and 15 cm. of mercury; this is sufficiently well marked to enable us to dispense with cardiac tonics. The pulse rate usually declines with the temperature. It may rise somewhat in presence of an unusually intense reaction, but this is of no particular gravity. I have seen plenty of patients with a pulse rate of 150, which is regarded as of fatal significance, yet they recovered.

The urinary secretion greatly increases in amount. Whereas the polyuria usually only supervenes with convalescence, in injected patients it is observed in the course of a few days, and sometimes amounts to 8 or 10 pints. If there be albuminuria before the injection, it soon subsides after it, and it is very rare for patients who were not albuminuric when injected to become so afterwards.

The influence of the serum on the temperature curve is appreciable for ten or twelve days, after which either convalescence sets in or the temperature continues to fall until recovery, the attack being comparatively short, or else, in the graver cases, the defervescence is stationary for some days, remaining above normal, as if the remedy no longer produced any effect, then convalescence sets in in the absence of a relapse. In any case the relapse usually only lasts a few days, especially when the original attack has been severe.

Convalescence is usually rapid, especially in patients treated early. Nevertheless, those in whom the disease has been promptly arrested by the serum, must take great care for some weeks to come, for I have occasionally seen a patient relapse two or three months later. This persistence of the microbe is, indeed, a well-recognised occurrence, and is manifested by osteitis and periosteitis. In this connection I must mention the remarkable effects of a small injection of serum *in loco dolenti*. We are aware that, as a rule, osteitis is of protracted duration, and usually ends in suppuration requiring surgical intervention. As soon as there is swelling and nocturnal pain, we need only inject one drop of the serum into the centre of the lesion, whereupon, within a few hours, the pain subsides, the swelling disappears, and recovery takes place in two or three days. The same treatment is applicable in the event of orchitis or typhoidal mammitis.

The low mortality in my thousand patients is evidence *per se* that complications must have been infrequent. Intestinal hæmorrhage only accounts for 4 out of the 47 deaths, while perforation accounts for 19, so that the treatment appears to protect less against this complication than others. This is explained by the fact that the intestinal lesions are the first to occur, and are already present when the injection is carried out, hence the importance of injecting early. I have never met with intestinal perforation in patients injected within seven days of the onset.

I have made a number of observations in order to ascertain whether the conjunctivæ of typhoid patients displayed a marked sensitiveness to the bacillus which might be useful in arriving at a diagnosis. Such is actually the case, and it may be well for me to describe the mode of employment of the test. The test solution is prepared as follows: A layer of gelose in a flat bottle is inoculated with the virulent bacillus and placed in the warm chamber for 18 or 20 hours, by which time the surface has become covered with a culture, which is removed after adding 4 or 5 cc. of sterilised water, and the bacillary mass is poured into a large tube. This is heated over a water bath at 60° C. to destroy the vitality of the bacilli; it is centrifugated, and the bacilli are dried *in vacuo*. The microbial mass is rubbed down in an agate mortar, with a little chloride of sodium. When thoroughly rubbed down we add 4 cc. of sterilised water, and continue the process, gradually adding water to the extent of 100 grammes for, say, 3 grammes of the microbial mass. The tube is then set aside to repose for two days, heating it to 60° daily for half an hour. The supernatant liquid is then decanted. It is almost transparent, and, should any flakes be present, it is again centrifugated. It should be but slightly opalescent when it is slowly poured into ten times its bulk of alcohol. The alcohol becomes cloudy, and is allowed to deposit for three hours, when it is decanted, and the coagulum that has formed at the bottom is rapidly dried *in vacuo*. We thus obtain a yellow mass, which is rubbed down to a fine powder in an agate mortar. When to be used, the powder, which contains a small proportion of toxin adherent to a substance that reacts to the test for albuminoids, is triturated, and it dissolves slowly, in the proportion of 10 milligrammes to 1 cc. of water—that is to say, enough for twenty observations. Thus prepared, the powder keeps very well in a closed bottle. The resulting fluid should be opalescent and free from flakes.

One drop of the solution is dropped into the lower conjunctival cul-de-sac, the patient's head being thrown back to prevent it escaping. Within two or three hours there is a sensation of heat, and the redness extends to a caruncula; there is some weeping and fibrinous exudation. The effect attains its maximum in from six to ten hours after instillation. The intensity of the reaction depends on two factors: first, on the sensitiveness of the patient, which varies within wide limits; and, secondly, on the quantity instilled. The quantity given has been shown by experience to be sufficient to determine a reaction in typhoid patients, and not in others. But the typhoid toxin is irritating *per se*, and what we must rely upon is not the existence of a reaction, but its intensity and its persistence.

The point to which I attach particular importance, since I have never found it wanting in true typhoid, is the persistence of the redness. This persistence is easily detected by comparison with the untreated eye. It may persist for one, two, or even five or six days, after which it clears up. After upwards of 200 observations, I have never seen the slightest untoward effect. Fifty persons suffering from non-typhoidal diseases gave no reaction, with one exception—that of a tuberculous woman who had had typhoid two years before, and in this case it had disappeared on the following day. Sixty-seven patients with well-marked typhoid gave a positive reaction.

The most interesting feature of this research is the following: Several times at the onset, or in the course, of an attack of typhoid fever, the ophthalmo-diagnosis gave a positive result, while the sero-diagnosis was negative, and only became positive several days later. As a matter of precaution the ophthalmo-diagnosis should only be tried in eyes which appear normal and healthy, or naked eye examination and the reaction should be quite apparent after 24 hours. It is possible that this delicate reaction may ultimately lead us to include among typhoid affections slight febrile attacks in which the sero-reaction proves negative.

The serum I employ is obtained from horses in which intravenous injections of virulent microbes have been practised for a long period, or the soluble typhoid toxin injected beneath the skin.

The soluble toxin is prepared by cultivating in flat bottles, in a bouillon of ox spleen, very virulent typhoid bacilli. The bacillus develops on the surface, and the toxins are elaborated beneath. In seven days this is collected in small bottles, and heated to 55° C., and centrifugated. The injections in the horse must not be repeated at too short intervals, for each one determines a sharp rise of temperature, and the horse becomes immunised but slowly. Those give the best results that have been injected periodically for several years. The properties of the serum vary somewhat according to the lapse of time that has taken place since the last injection of toxin. It attains its maximum preventive power in about 20 days.

Only small doses are required, and I have been able, by using the serum of animals injected for several years, to use only a few drops for each injection, a dose sufficient to determine the modifications in the course of the disease already referred to.

The influence of an injection lasts about 10 days. I rarely make a second unless the disease displays a tendency to become protracted, and in such case the second injection should be less in amount than the first, for it sometimes gives rise to local tumefaction, a result that never follows the first injection.

Injected into healthy rabbits and guinea-pigs, the serum gives rise to no constitutional symptoms. Animals previously injected resist inoculation with a quantity of typhoid toxin that proves fatal to animals not so protected. If the toxin and the serum be injected separately but simultaneously, the action of the former is almost as intense as when no serum is used, but the leucocytic defence is vastly more rapid and energetic than in animals where no serum is used; moreover, the blood returns to normal much more promptly. If the injection of serum be made too late—*i.e.*, in presence of urgent symptoms of intoxication—the favourable reaction is, so to speak, inhibited, and is not produced. The effects of the serum last for some time, and animals that have been injected therewith six or seven days previously still manifest marked resistance to subsequent injections of the toxin.

In order to properly grasp the action of the immunising injection, we must examine the spleen and bone marrow of the animals under observation. The difference in animals thus treated and the control animals is so marked as to be visible even to the naked eye.

The effect in the healthy man and the typhoid patient is exactly the same as in animals. Phagocytosis is stimulated in a marked degree—in fact, the state induced in the organism of the typhoid patient by the injection of the anti-typhoid serum is one of opsonisation. This is shown by estimating the opsonic index in patients subjected to serotherapy. The opsonic index by Wright's method is the relationship between the power (to take up typhoid bacilli), which leucocytes possess in normal human serum, and the power which these same cells acquire under the stimulus of typhoid blood either before or after the injection of serum.

The opsonic index is somewhat variable, according as we are dealing with a slight or severe form of the disease. In mild cases the opsonic curve shows that the opsonic index is high even before the injection of serum—*i.e.*, 2.1 (unity being the normal). The day following the injection the opsonic index rises, reaching its highest point on the fourth day; then it falls a little as the injected serum is eliminated and defervescence sets in, while the patient's serum contains a progressively higher quantity of opsonines. When convalescence is well marked the opsonic index remains high for a month or so after recovery. When convalescence is protracted, the opsonic index is lower.

In severe cases the opsonic index is low before the injection, after which there is a sudden and marked rise during the three or four following days. This period, no doubt, corresponds to wholesale destruction of bacilli throwing toxic products into the blood of the patient already intoxicated by the typhoid fever, and the patient reacts by a rise of temperature which is the phenomenon of the reaction; hence the desirability, in severe cases, of restricting the destruction of bacilli by only employing very small doses of the serum.

Between the fourth and twelfth day after the injection the curve of the index falls, although remaining above what it was before the injection. Then in severe cases the index oscillates round a fixed point until recovery ensues.

We must avoid giving the patient too severe a shock or we run the risk of inhibiting the production of opsonines. When the case takes a turn for the worse, as, for instance, in the event of intestinal perforation, the opsonic index steadily falls until the fatal result supervenes.

Already in 1902 I pointed out that "the graver the illness the smaller must be the dose of serum." This struck many as a strange utterance, but it is now explained and justified by observation of the oposonic curves.

It may be asked why, being in possession of such a powerful means, I still employ cold baths. My answer is that the baths are necessary to assist the patient in resisting the pyrexial reaction that follows the injections. Anti-typhoid serum is not an absolutely complete treatment, but it is one of great power which we have to learn how to use. At Cairo, in 1902, I suggested that "by the addition of anti-typhoid serum to hydrotherapy the typhoid mortality might be reduced to 4 or 5 per cent." Five years have passed since that time, and a much larger number of cases of typhoid fever have been treated at the hospital, and I have nothing to modify in that suggestion.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Harry Campbell, M.D., F.R.C.P., Lond., Physician to the West End Hospital for Nervous Diseases. Subject: "The Diet of the Aged."*

ORIGINAL PAPERS.

INTERSTITIAL KERATITIS FROM A MODERN STANDPOINT. (a)

BY SYDNEY STEPHENSON, M.B., C.M.,

Editor of "The Ophthalmoscope."

IT would be difficult or impossible to over-estimate the diagnostic importance which attaches to some of the ocular stigmata of inherited syphilis. By their discovery the nature of many and many an obscure case has been cleared up. I can recall a couple of cases of necrosis recognised as syphilitic in one instance by the finding of disseminated choroido-retinitis, and in the other by the advent of interstitial keratitis. The most striking case with which I am acquainted, however, was related by Edmond Fournier in his monograph on late heredito-syphilis (" Recherche et Diagnostic de l'hérédo-syphilis tardive," 1907, p. 325). A man, æt. 34, was believed to be suffering from sarcoma of the pelvis, declared by three competent hospital surgeons to be beyond the reach of operation. The patient's elder brother, æt. 36, was examined by my friend Dr. Antonelli, with the ophthalmoscope, and found to be affected with positive stigmata of congenital syphilis. The result of this discovery was happy in the extreme. For after two months' treatment by mercurial injections and potassium iodide, the pelvic growth disappeared without leaving a trace and the patient was restored to perfect health. His remark was amply justified when he exclaimed: "*J'ai été sauvé par les yeux de mon frère.*"

Of all the ocular manifestations of inherited syphilis, none is better known or easier to recognise than diffuse interstitial or parenchymatous keratitis.

The disease is not exactly a common one. For example, Greeff, (*Die Keratitis interstitialis in ihren Beziehungen zu Allgemeinerkrankungen*, 1897) collected figures respecting 36,385 eye patients, and found that interstitial keratitis had been diagnosed in 297—*i.e.*, in 0.77 per cent. of the total number. Again, among 5,142 eye patients seen by me at the North-Eastern Hospital for Children, London, 49, or 0.95 per cent. were affected. The proportion would naturally be somewhat higher at a children's hospital than elsewhere.

The disease has been familiar to surgeons for many years. Wiilliam Mackenzie (" A Practical Treatise on the Diseases of the Eye," 1830, p. 419.") who takes in ophthalmic science the position occupied by Sir Thomas Watson in general medicine, was acquainted with the malady, which was called by him "scrofulous corneitis." Mackenzie noted its coincidence with deafness, a peculiar hoarseness of voice, swollen lymphatic glands, nodes on the tibiæ, and effusion into the bursa beneath the tendon of the extensores cruris, symptoms some of which we now recognise to be manifestations of inherited syphilis.

It was, however, reserved for Jonathan Hutchinson (" A Clinical Memoir on Certain Diseases of the Eye and Ear, consequent on Inherited Syphilis," 1863) to show that interstitial keratitis was " almost always a direct result of inherited syphilis," and to give a description of its clinical characters and morbid associations that is as truthful to-day as when he wrote it forty-four years ago. In particular, Hutchinson drew attention for the first time to the diagnostic value of certain malformations of the teeth often met with in cases of interstital keratitis.

A few years later James Dixon (" A Guide to the Practical Study of Diseases of the Eye," third edition, 1866, p. 95) went farther, and proposed to substitute for Hutchinson's name, " chronic interstitial keratitis," that of " syphilitic keratitis," since there existed, he said, " no special form of keratitis connected with acquired syphilis."

Still more recently, Hutchinson (" Syphilis," London, 1889, p. 75) has claimed that " interstitial keratitis in its typical form is always a consequence of syphilis, and is in itself sufficient for the diagnosis."

To some extent, however, the pendulum of professional opinion has now swung back to the views expressed so many years ago by William Mackenzie. The view current to-day, especially upon the Continent, is, that while parenchymatous keratitis is usually a manifestation of inherited syphilis, yet a proportion of the cases are due to other factors, among the more important of which are tuberculosis, acquired syphilis, influenza, malaria, and trypanosomiasis. In a word, it will scarcely be denied that interstitial keratitis is the local manifestation of some general disorder, be it syphilis or otherwise.

It will clear the ground if a few figures be quoted as to the relative frequency of inherited syphilis as a cause of interstitial keratitis. Davidson found 20 per cent., Alexander 35.3 per cent., Fournier 41.5 per cent., Hirschberg 61 per cent., Sæmisch 62 per cent., Horner 64 per cent., Mauthner 80 per cent., Bosse, 81 per cent., and Silex 83 per cent. of the cases to be due to a specific cause in the shape of inherited syphilis. Pfister (*Klin. Monatsbl. f. Augenheilkunde*, XXVIII., 1890 p. 114) found certain evidence of hereditary lues in 40.8 per cent. of his 130 cases and presumptive evidence in 23.8 per cent.—total, 64.6 per cent. Nettleship (" Diseases of the Eye," fifth edition, 1890, p. 120) found personal (54 per cent.) or family (14 per cent.) evidence of inherited syphilis in 68 per cent. of an unspecified number of cases, and in most of the remaining 32 per cent. there were strong reasons for suspecting its existence. My own figures, dealing with 101 cases, gave inherited syphilis in 70 or 69.3 per cent.

Other statistics might readily be quoted, but enough have been given to show that, broadly speaking adequate evidence of inherited syphilis may be obtained in about two-thirds of all cases of parenchymatous keratitis.

With regard to the frequency of tuberculous interstitial keratitis, some interesting figures have recently been published by H. Rabiger (ref. in *Archives of Ophthalmology*, November, 1907, p. 875). In 349 cases of keratitis observed at the University Polyclinic at Berlin, tuberculosis was found with certainty in 11 per cent., and with probability in 9.7 per cent.—total, 20.7 per cent. In my own series of 101 cases tuberculosis was identified as the cause of the keratitis in 10—that is, in 9.90 per cent. The more extended employment of Calmette's serum test will doubtless help us to recognise such cases with more certainty.

It would appear that interstitial keratitis is by no means rare as a late, tertiary consequence of acquired syphilis. The connection was first mentioned by Velpeau in 1840 (" Maladie des Yeux,") and was described in 1861 by Follin (*Pathologie Externe*, T. I., p. 708, 1861)—that is to say, two years before the publication of Hutchinson's famous memoir, in which he commented on " the entire absence of interstitial keratitis from the *rôle* of tertiary symptoms of acquired syphilis " (*loco. citato.*, p. 221). In a later work (" Syphilis," 1889, p. 237), however, Hutchinson modified this view, and recognised the possibility of an acquired interstitial keratitis.

According to figures collected by Pfister from Professor Haab's klinik (*loco citato*), of 130 cases of keratitis 3.8 per cent. (2.3 per cent. certain and 1.5 per cent. somewhat doubtful) were due to the acquired disorder, while Ancke (*Centralb. f. prak. Augenheilkunde*, 1885, p. 360) found the proportion in 100 cases to be as high as 10 per cent. Among my series of 101 cases of parenchymatous keratitis, 4, or 3.96 per cent. were unquestionably due to acquired syphilis.

(a) A contribution to the discussion on Inherited Syphilis, at the Society for the Study of Disease in Children, on December 18th, 1907.

It is important to note that such cases have been met with, even in children. For example, Mauthner (Zeissl's *Lehrbuch der Syphilis* p. 279) saw a case of interstitial keratitis in a suckling that had contracted syphilis from its nurse. Moreover, Trousseau (*Annales d'oculistique*, September, 1895, p. 206) has mentioned the case of a boy, æt. 8, who was infected by his nurse with syphilis. The result was a very severe attack of bilateral keratitis. Lastly, I reported a case of the kind (*The Ophthalmoscope*, Vol. I., 1903, p. 169) in a girl, æt. 12, who had suffered from a chancre on one upper eyelid two or three months after birth.

It may be noted as an interesting point that quite a number of cases of interstitial keratitis have been known to follow an indurated chancre on the eyelid or conjunctiva.

The name "interstitial keratitis" is good in so far as it directs attention to a prominent feature of the malady—namely, to opacities "like microscopic masses of fog," situated at various levels in the substance of the cornea. It suggests, nevertheless, a mistaken view as to the pathology of the condition (Fuchs, v. Hipple, Pfluger, de Lapersonne, C. D. Marshal, Parsons, &c.). The available evidence indicates that the ailment is primarily an inflammation of the tissues of the ciliary body, which forms (as everybody knows) the middle part of the uveal tract, of which the other parts are the iris and the choroid. From the ciliary body inflammation spreads forwards to the iris as well as to the deeper layers of the cornea, and backwards to the anterior parts of the choroid. Keratitis and the commonly associated choroiditis and iritis, therefore, are, strictly speaking, conditions secondary to an inflammation of the ciliary body. The underlying process may conveniently and accurately be described by the expression "anterior uveitis."

If this view be not grasped, it becomes difficult to understand some clinical features of the disease. For example, in my experience, it is not very uncommon for the ailment to begin with what appears to be an accumulation of pus in the anterior chamber of the inflamed eye (*a*). This hypopyon, of course, represents an exudation from the inflamed ciliary body, which has passed through the pupil and has thereby gained the anterior chamber. Another early sign is the existence of deposits on Descemet's membrane, the "aquo-capsulitis" of the older, and the "keratitis punctata" of the more modern, writers, and this, again, is to be regarded as the expression of an exudation from the ciliary body. The occasional bleeding into the anterior chamber (hyperæmia), which may usher in an attack of parenchymatous keratitis, is almost certainly due to the rupture of some small distended vessel in the ciliary body. None of these appearances can be explained on the theory that the disease is primarily one of the cornea.

Further, the iritis which often precedes or accompanies the keratitis can be best accounted for by an extension forwards from an inflamed ciliary body.

A similar remark applies equally to the choroiditis which is frequently found when the cornea has cleared enough to allow of an examination of the fundus with the ophthalmoscope. In cases where choroiditis is known to precede by months or years the development of keratitis, the backward extension to the choroid has antedated the forward extension to the cornea, or has possibly occurred independently of the ciliary inflammation. Cases of this type are sometimes of an unusually severe type. The following is an example: John O——, æt. 8, first seen on January 5th, 1893. A typically syphilitic subject, with "bossy" forehead, rhagades, and dwarfed and notched upper central incisors, and a tendency to ptosis. Sight equalled about one-fifth of the normal, as the result of widely-spread, bilateral choroido-retinitis. In September, 1893, the right eye developed interstitial keratitis, and seven months later (April 25th, 1894) the left eye followed suit. On May 30th each knee-joint became distended with fluid. The corneæ presented a peculiar appearance, since an irregular area towards the centre, 5 mm. at its widest part, resembled damp wash-leather, and was everywhere surrounded by a zone of plum-coloured vascular tissue—a confluent "salmon patch," in short. Viewed from the side, the cornea projected forward cone-wise, the blunt apex of the cone being formed by opaque cornea and its sides by the vascular patch. By this time the lad had become somewhat deaf, without discharge from the ears. On June 19th, a portion of the grey opaque central area had exfoliated. Deafness was increasing. Both ankles had become swollen. In August, 1894, the lad developed delusions, which became very pronounced towards the end of that month. He used vile language, insisted upon getting out of bed for the express purpose of breaking the windows of the ward or, for that matter, anything else he could grope his way to, for by this time he was, to all intents and purposes, blind. John O——,was then transferred from the Ophthalmic School to another institution, where "he developed most acute mania, and had delusions that people were coming to kill him and that there were bloodhounds in the cupboard." In 1902—that is, nine years after I first saw him—the patient was an inmate of Darenth Asylum, quite blind, and suffering from imbecility with occassional attacks of excitement. One of his eyes had been removed owing to an injury.

The case just described presented several peculiarities, and amongst them ulceration of one cornea. This complication, in my experience, is not common. For instance, among my 97 cases (*a*) of interstitial keratitis it occurred in 4—that is to say, in 4.12 per cent. That it might occur was known to Hutchinson, who alluded to one or two cases on page 29, of his oft-quoted memoir. W. Spencer Watson (*Ophthalmic Hospital Reports*, Vol. IV., p. 296), writing a few years after Hutchinson, reported an instance of unilateral ulceration observed in a series of twenty-five cases of interstitial keratitis, R. Ancke (*Centralb. f. prak. Augenheilkunde*, 1885, p. 296) had one example of ulceration among 100 cases of interstitial keratitis. E. T. Collins (*Ophthalmic Hospital Reports*, Vol. XI., 1887), described four cases in corneæ which showed extreme vascularity, and in which a small central island of non-vascular tissue was alone left. This islet became yellow and then ulcerated. In one of Collins' cases there was perforation, but cicatrisation took place in the other three. His patients showed unmistakable signs of inherited syphilis, either in the teeth or the physiognomy.

In a majority of cases of parenchymatous keratitis, one cornea is first attacked and the other cornea, according to Hutchinson (*loco citato*, p. 29), "after from one to two months." But it should be borne in mind that the interval may be and often is much longer than this. The extreme instance reported by Consiglio (*Beitrage z. Augenheilkunde*, May, 1905), where the interval amounted to twenty-six years, must be almost unique, although in his case the evidence of inherited syphilis was not altogether conclusive. My own series includes one case where the interval amounted to about seven years, The facts follow:—Edmund D——, æt. 13, seen on December 22nd, 1899, with early interstitial keratitis affecting the right eye, which had been divergent since infancy. After making a nearly complete recovery, the right eye relapsed in September, 1905. On November 30th, 1906, the following note was made: "The left eye has been affected for the last fortnight—*i.e.*, there has been an interval of seven years between the attacks in the two eyes. The patient is deaf and his teeth are typical of inherited syphilis. Hutchinson's triad is therefore present."

All observers agree that parenchymatous keratitis is essentially a disease of childhood. On this point there is no difference of opinion. It is, nevertheless, relatively rare in very young children, and equally so after mature age has been reached. Hutchinson, for example, had never witnessed its occurrence earlier than two years or later than twenty-six years. It is most frequent between the ages of five and eighteen

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(*a*) Hypopyon was present in many of my 101 cases of Interstitial Keratitis.

(*a*) Four cases due to acquired syphilis omitted.

years (Hutchinson), or of six and fifteen years (Nettleship).

The age-incidence of my 97 cases, arranged in quinquennial periods, comes out as follows :—

Period.	Number.	Percentage.
1 to 5 years	6	6.19
5 to 10 ,,	38	39.18
10 to 15 ,,	26	26.80
15 to 20 ,,	14	14.43
20 to 25 ,,	8	8.25
25 to 30 ,,	2	2.06
Over 30 ,,	3	3.09

An inspection of the foregoing figures will at once show that of my 97 cases, four-fifths, or 80.41 per cent., occurred between the ages of 5 and 15 years. My series includes one case in a woman, æt. 36, whose syphilitic inheritance was attested by notched upper central incisors, rhagades at angles of the mouth, and by a node on the frontal bone, one inch above the inner end of the left eyebrow. R. Marcus Gunn (*The Polyclinic*, December, 1902) reported a case in a patient, æt. 36 ; Pfister, (*loco citato*) in a man æt. 37½ ; and Greeff (*loco citato*, p. 13) in a man of 38 years.

The rule that syphilitic parenchymatous keratitis is relatively commoner in females than in males, is supported by an analysis of my own cases, 97 in number. Of the total, 37 (38.14 per cent.) were in males, and 60 (61.86 per cent.) in females. It is, perhaps worth noting, that the same curious disproportion between males and females applies also to juvenile tabes dorsalis. Thus, Cantonnet (*Archives d'ophthalmologie*, November, 1907), as the result of an analysis of 88 cases, found that females were affected in 63.6 per cent, and males in 37.3 per cent.

It should be noted that the figures given by Baker and Story (*Ophthalmic Review*, November, 1885), and by Ancke (*Centralbl. f. prak. Augenheilkunde*, 1885, p. 360) respectively form an exception to the general experience as to the age-incidence of keratitis, as stated above.

The discovery of the specific cause of syphilis in the shape of the treponema pallidum, together with the possibility of inoculating apes, rabbits (*a*) and dogs with the virus, has widened our conception of the morbid processes that lead up to the development of interstitial keratitis. The disease in question has been produced experimentally in certain animals by the implantation of syphilitic products. Indeed, prior to the discovery of the treponema, P. Salmon (ref. in *Archives d'ophtalmologie*, April, 1905, p. 1623) observed iritis and keratitis thirty-three days after a monkey had been inoculated with a syphilitic papule from man.

We know that the tissues and organs of the syphilitic fœtus or baby are literally flooded with the treponema, large numbers of which have been found in the placenta, the umbilical cord, the blood of the umbilical vein, and especially the liver. The organisms that escape the liver are distributed by the fœtal circulation to every part of the body, where they determine this or that syphilitic lesion. The treponema has been found in cutaneous lesions, as pemphigus, by Levaditi and others, in perioral ulcerations by Elizaldi and Wernicke, in glandular lesions by Panea and Babes. That is by no means all, for apart from definite lesions such as those named, the treponema had been found in every internal organ so far examined with the microscope. As regards the eye, the findings from our present point of view are highly suggestive. Thus, Hans Bab (*Deutsche Med. Wochenschrift*, November 29th, 1906) examined the eyes of three specific still-born babies. Preparations were treated by the silver impregnation method, and large numbers of the spirochætes were found in all the tissues of the eye, with the exception of the vitreous humour and the crystalline lens. It is important to note that the cornea contained a large number of the organisms. Again, H. Schlimpert (*Ibid*, 1906, p. 1942) succeeded in discovering the treponema in various parts of the eyes of syphilitic fœtuses. Lastly, spirochætes have been demonstrated in the tissues of seemingly unaffected eyes of syphilitic fœtuses and babies by some other observers, including Peters, Gierke and Stock and myself.

It would thus seem probable that if the child survive, these micro-organisms (possibly in some different morphological form) lie dormant in the tissues of the eye, more especially in the ciliary body and the cornea, They cause no mischief until some exciting cause, of a local or general nature, lowers the resistance of the part, and allows the treponema to come into action. The result is an attack of interstitial keratitis.

In this view we can explain an observation made by many surgeons—namely, that a slight injury to the eye may precipitate an attack of parenchymatous keratitis. I well remember the first case of this kind that happened in my practice. A girl, æt. 11, was admitted to the Ophthalmic School, Hanwell, for trachoma, pannus, and lead opacities of each cornea, in consequence of which the child was almost blind. Her syphilitic diathesis was attested by (1) notched central incisors of the upper jaw ; (2) scars radiating from the mouth, the so-called " Fournier's cicatrices"; (3) " epithelial denudations " (*a*) about the skin of the upper lip and nose ; (4) slightly enlarged lymphatic glands ; and (5) cicatrices about the anus and buttocks, the so-called " Parrot's cicatrices." On March 16th, 1897, under cocaine, the metallic incrustations were more or less scraped away from the right cornea by means of a small, sharp scoop. The little operation, somewhat to my surprise, was followed by redness of the eye, and by increased haziness and vascularity of the cornea—in a word, by the clinical appearances of an ordinary parenchymatous keratitis. On May 4th —that is, forty-nine days after the operation—the condition was typical of interstitial keratitis. In view of etiology, the case was an interesting one, and so on June 16th, the operation was repeated on the other eye. I am bound to add that the second intervention was not followed by interstitial inflammation. Be that as it may, the association between slight injury to the eye, on the one hand, and parenchymatous inflammation, on the other, is far from uncommon, as will be obvious from the fact that I possess notes of fifteen such cases.

Interstitial keratitis may supervene during the course of illnesses, such as influenza and typhoid fever. Here are one or two cases in point :—

Ellen W., æt. 11, was admitted to the North-Eastern Hospital for Children under my colleague, Dr. James Taylor, on account of typhoid fever. On the seventeenth day of the fever (approximately) the left pupil was noticed to be contracted and the cornea of the left eye rather dull. When seen by me five days later, there could be no doubt that the case was one of parenchymatous keratitis. The girl had suffered from periostitis of the right tibia for several weeks. Three months after the first eye had been attacked, the other cornea went through a much milder attack of keratitis. Florence G——, æt. 8, a child who presented rhagades at the angles of the mouth, a *café au lait* complexion, and suspicious incisor and molar teeth, in addition to slight deafness, was brought to the Evelina Hospital on March 15th, 1905, for a relapsed interstitial keratitis of her right eye. The history was to the effect that three years before, about a fortnight after her discharge from an Asylums Board Hospital, where she had spent three months on account of enteric fever, both eyes became inflamed, one soon after the other. The condition had slowly improved until a relapse a few weeks before the child was brought to me.

I have also seen interstitial keratitis follow a whitlow so closely as to suggest a connection between the two affections.

It is now, I think, generally recognised that interstitial keratitis may relapse—or, more correctly,

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(a) As long ago as 1881 Paul Haensell (v. Graefe's *Archiv. f. Ophtalmologie*, XXVII, III, p. 93) showed that syphilitic virus could be successfully inoculated into the iris and cornea of the rabbit.

(a) The expression "epithelial denudation" I apply to those superficial cicatrices, whose favourite site is at the junction of the ala nasi with the upper lip. Their significance and diagnostic value is the same as Fournier's cicatrices.

recur—in one and the same patient. Manasse, in 50 cases had 8 recurrences, or 16 per cent., and v. Hippel, among 87 cases, 15 recurrences, or 17.25 per cent. The proportion in my own cases, many of which remained under observation for long periods of time, was somewhat higher, namely, 22 per cent. As to the explanation of recurrences we must assume that spirochætes have remained dormant in the tissues of the cornea as a sequel of the primary attack. I believe that recurrences are commoner in cases originally treated without than with mercury, and I am confident that, as a rule, they are more difficult to manage than that original attack.

Experimental Keratitis.—Bertarelli (*Presse Médicale*, August 22nd, 1906) obtained a positive result by inoculating the cornea of rabbits with an emulsion of human chancres. The animals' corneæ showed numerous spirochætes, and, in addition, a pronounced leucocytic infiltration, which extended into the seemingly unaffected parts of the cornea. Scherber and v. Benedek (*Munch. Med. Wochenschrift*, June 14th, 1906) produced nodular iritis and interstitial keratitis by inoculating the anterior chamber of rabbits with syphilitic virus. Most suggestive experiments were reported during the course of 1906 by Greeff and Clausen (*Bericht der Oph. Gesellschaft*, Heidelberg, 1906), who inoculated the eyes of apes and rabbits with syphilitic material, and after the lapse of some weeks, observed the development of a kind of parenchymatous keratitis. In the earlier cases, numerous spirochætes could be demonstrated, but the organism could not be found in the more advanced cases. The authors concluded that the corneal opacity was the outcome of a leucocytic invasion, which attacked and eventually destroyed the micro-parasite.

In a second communication (*Deutsche Med. Wochenschrift*, 1906, No. 36), Greeff and Clausen concluded that the pathogenic agents of syphilis multiplied in the cornea, and thus caused an invasion by leucocytes, which finally exterminated the micro-organisms. Lastly, Hoffmann and Bruening (*Deutsche Med. Wochenschrift* April 4, 1907) produced keratitis by the inoculation of a rabbit's eye with a morsel of a human chancre, and obtained a somewhat similar result when an emulsified chancre was introduced into the anterior chamber. Smears from the diseased cornea, when stained by Giemsa's method, showed the spirochæta pallida, thereby proving the essentially syphilitic nature of the keratitis.

Panas (*Archives d'ophtalmologie*, 1871, p. 577) taught that interstitial keratitis was a dystrophic symptom, the indirect cause of which was to be sought, not only in ancestral syphilis but also in lymphatism, scrofula, gout, and arthritism. It is now suggested, mainly as the result of experimental and histological researches, that it is, in reality, an infection of the tissues of the cornea with this or that specific organism, the most important of such being the treponema pallidum, the tubercle bacillus, the B. influenzæ, the plasmodium malariæ, and the parasite of trypanosomiasis.

In brief, it can nowadays scarcely be doubted that syphilitic interstitial keratitis is due to the presence in the parenchyma of the cornea of the causal agent of syphilis. The treponema, however, has yet to be demonstrated in that structure. The hiatus on this vital point is not to be wondered at, since eyes are seldom, if ever, removed during the height of parenchymatous keratitis, nor do patients usually die during the course of that affection. Speaking for myself, I have failed to find the spirochæte in scrapings from eyes affected with keratitis; but, then, superficial parts only were removed. Despite the known difficulty of recognising the treponema in tertiary syphilitic lesions, it is safe to predict that sooner or later the organism will be discovered in the tissues of the cornea. The chain of evidence, which still lacks one link, will then be complete.

Aphorisms Respecting Interstitial Keratitis.

1. Interstitial keratitis is not a primary affection of the cornea, but is probably in every instance secondary to changes in the anterior part of the uveal tract.
2. The disease is nearly twice as frequent in females as in males.
3. Four-fifths of the cases occur between the ages of five and fifteen years.
4. The disease can be shown in about two-thirds of all cases to be associated with signs of inherited syphilis, of which the commonest are the dental, facial, and ocular stigmata. Other important causes of the disease are tuberculosis, acquired syphilis, influenza, malaria, and sleeping sickness.
5. Given a predisposing cause, the affection may be excited by almost anything that lowers resistance, local or general.
6. Ulceration of the cornea occurs in a notable percentage of all cases.
7. The ailment is bilateral in three-fourths of the cases. The interval between the two eyes being attacked may, however, run into several years.
8. Recurrences occur in perhaps one-fifth of the cases, are commoner in cases treated without than with mercury, and are often very difficult to manage.
9. The disease is due to the lodgment and multiplication in the cornea of the treponema pallidum derived primarily from the uveal tract.
10. Interstitial keratitis does not form more than 1 per cent. of the cases met with in a special department for diseases of the eye.

ON EYE STRAIN. (a)

By HERBERT C. MOONEY, B.Ch., F.R.C.S.,

Ophthalmic Surgeon to the Children's Hospital, Dublin.

In the short paper which I am about to read to you, I have brought together some symptoms of neuroses which one meets with in eye work, and which, although varying very much in their severity and distribution, are generally grouped under the term "Eye Strain."

Although it is a long time since Donders described the errors of refraction of the eye, and since Weir Mitchell wrote articles in which he brought forward the part played by the eye as a cause of headaches, yet it would appear that the relation which errors of refraction bear to headaches and other neuroses is not as generally appreciated as it should be.

When we consider the condition of affairs when the eye is provided with an imperfect refractive system, it is not surprising that some evil results therefrom. Take the simplest case, that of hypermetropia. Here, in order that the retina may be provided with perfect images the ciliary muscle must be kept in a constant state of tension from morning till night. With the exception of the circulation and respiration, is any other system expected to do as much? Even the stomach, which stands a fair amount of ill-treatment, breaks down, I believe, when subjected to a constant call on its functions. When the refractive error is one of astigmatism we have a stronger reason for nervous exhaustion, for in this case there is an inequality in the refraction of the principal meridians of the eye, with a result that the images presented to the retina for its elaboration are not alone blurred, but they are also distorted images of the object looked at. No effort on the part of the ciliary muscle can correct this condition completely, whatever it may accomplish in reducing the distortion, so that the work of the retinal elements and the visual act as a whole is considerably increased, with a resulting fatigue somewhere.

Many patients who complain of headaches will not believe that their eyes have anything to do with the trouble, because they are satisfied (and rightly so) that they can see as well as the best. A patient of mine, a Queenslander, complained of headaches. Without glasses the vision of each eye came up to our normal standard. With corrective cylinders of ÷ 1 D this acuity of vision equalled 5 / 2.5—*i.e.*, twice as good as the accepted standard. But it must be remembered the visual act is not con-

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(a) Read at the Medical Section of the Royal Academy of Medicine in Ireland, December 6th, 1907.

fined to focussing images on the retina. There is the fusion of these images of the two eyes to be accomplished by the six pairs of extrinsic muscles. So that, with two emmetropic eyes and a complete accommodative system, we may have some irregularity or want of symmetrical action between the various pairs of the extrinsic muscles. Those which are concerned most with vision for different distances are the lateral recti, and these are the muscles which we find most at fault. But even these recti may possess a moderate degree of a symmetrical action without producing symptoms, but a very small degree of defect in the action of the elevators or depressors of the globe usually produces a discomfort of a marked degree, and is often the cause of the most distinct symptoms of eye strain. Having thus briefly viewed the possibility of the intrinsic or extrinsic muscles, acting individually, being a cause of strain, or asthenopia, we must recognise that when they come to work together in cases where there are not only errors of refraction, but errors of different kinds in the two eyes, the source for eye strain is much widened. It is in cases of marked difference in the refraction of the two eyes, or want of balance in the extrinsic muscles, that we find cases of migraine occurring which are relieved by glasses.

Now to refer to the symptoms associated with eye strain. Of these headache is the most common. The pain may be across the forehead or at the root of the nose. It is usually bilateral, or may affect one side of the forehead or one temple. The pain may be referred to the vertex, a not uncommon site, or more rarely to the occiput. The pain varies very much in character, from being a constant dull ache to one which may be described as darting or neuralgic in character. The headache may be constant or intermittent, or noticed only when the eyes are applied to close work or, perhaps, may have no relation to the amount of near work performed.

In addition to the headache the patient may complain of apathy, giddiness, and sleeplessness.

The gastric symptoms sometimes met with take various forms, ranging from slight dyspeptic symptoms to nausea and vomiting. I am not anxious to work out the reflex path in such cases as these, but there would seem to be a connection between the nerves of the eye and the pneumogastric, for in cases of acute glaucoma, where pain and vomiting are the prominent symptoms, the real cause of the trouble may be overlooked, and a bilious attack diagnosed, with rather bad results to the vision of the affected eye. I have seen a very weak solution of eserin act sufficiently on the ciliary muscle to produce such giddiness and nausea, that the patient had to remain lying down for about six hours.

As already mentioned, migraine, with all its typical train of symptoms, is capable of being relieved, if not cured, by the suitable corrective lenses. These cases are usually found where the error of refraction is in one eye only, or where it differs in the two eyes From my own experience I am satisfied that I have seen cases of migraine relieved by the use of glasses. What I mean by relieved is, that the attacks become much less frequent. In one case in particular, where the pain was migrainous, but there were no characteristic scotomata or blind spots, and in which the attacks were frequent (one every eight or ten days), the use of glasses for reading brought about a reduction of the number of attacks to about one every month or six weeks, although the refractive error was very marked and differed in the two eyes, this lady would not wear her glasses constantly, as, of course, she should have done.

Children, as a rule, do not complain of headache, but they very often have hypermetropia or some form of astigmatism imprinted on their eyelids, as for example sties, chronic conjunctivitis and blepharitis, twitching and blinking of the lids. I have had an opportunity of seeing a good number of cases of ocular headache amongst the boys of one of our large schools. Their ages varied from 11 or 12 to 14 or 15, and their grievance was that the incandescent gas was too bright. Well, nearly all these cases, 9 per cent. of the whole school, had one form of astigmatism or another, so that I do not consider the quality or quantity of the illuminant had so much to do with the headaches as the astigmatism. I may remark here that I believe many of those who wear coloured or smoked glasses (in the absence of inflammatory affections of the eye, of course) would be able to discard the disfiguring glasses if they had their astigmatism corrected, for even the low degrees of astigmatism will produce an irritability or hyperæsthesia of the retina which renders the eye intolerant of ordinary diffuse day light.

As to treatment, I need not go into minutiæ. Suffice it to say, that each case must be carefully and deliberately examined by the various methods at our disposal, not refraining from the use of atropine or homatropine in certain cases. The routine testing of the balance of the extrinsic muscles with Maddox's rod and prisms should be adopted, for I have mentioned that the refraction of the eye may be quite normal, but the muscle balance faulty. It is well not to ignore the small degrees of astigmatism, such as .25D., for much may be done by the wearing of the weakest cylinders.

In conclusion, I would like to warn you against being put off your guard by the patient who wears glasses, who may complain of headache, telling you that his glasses are right because ordered by an experienced oculist. Very often in ordering cylinders it is right not to give the full correction, and such glasses will afford relief for two or three years, perhaps, but then the patient may have a return of his headaches, which will be probably cured by ordering the full cylindrical correction. In young persons the amount and axis of astigmatism are liable to alter, and, finally, persons who do not wear their glasses horizontally in front of their eyes are liable to produce symptoms of eye strain, although the glasses themselves may be quite correct.

When Dr. Oliver, of Philadelphia, wrote that asthenopia is the bane of the civilised minority, I think he was using strong language, but perhaps I have said a little towards justifying it.

THE EFFECTS OF THE RONTGEN RAYS ON LYMPHATICS AND MYELOID LEUKÆMIA.

By DR. EMIL EPSTEIN.

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[SPECIALLY REPORTED FOR THIS JOURNAL.]

IN discussing the Röntgen rays, it is necessary to explain the methods we practice in the Kienböck clinic, where such a wealth of material is to be found all the year round. The present remarks will be directed towards the hæmatic system, particularly four cases of leucocythemia, and the influence of the rays on this pathological tissue.

Native preparations are made from the blood of each patient, and the hæmoglobin measured by Fleishl instrument, while the corpuscles are analysed and carefully counted according to Turk's method given in his clinical hæmatology. The greatest difficulty we have is the selection of an eosin solution, as so many of these are now in use, all having individual advantages of their own. In the Kienböck clinic we have selected Zollikopfer's solution as a more stable fluid.

We use Müller's tubes, as prepared by Reimyer, Gebbert, Shull, etc. The rays have three measurements :—(1) The strength of the ray; (2) the radiometric measurement according to Sabourand-Noiré; and thirdly, the radiographic method adopted by Kienböck of quantimeter. The two latter are purely control measurements to prevent over-dosage by the first, and thus avert burning. Every sitting has a normal dose administered, *i.e.*, the maximal dose of Sabourand-Noiré, or 10 on Kienböck's quantimeter. The secondary current is between 4 and 5 deci-milliamperes, and the focus between 17 and 20 centimetres, or 7.87 inches. After receiving a dose of this kind the rays would not be applied for a month afterwards. To avoid misunderstandings in the descriptions, it might be noted here that Turk's terminology has been adopted.

Case I.—A merchant, æt. 44, whose mother was always healthy and lived eighty-four years, but father died earlier of inflammation of bowel. As far as the patient recollects, he was in good health till March, 1905, when he took middle ear inflammation, for which he was operated on. After this swellings commenced in the glands of the neck, some of which broke and discharged. Lues and potus negative.

When received into hospital, on June 13th, 1906, the patient was feeble, white, and emaciated. The cerebral nerves were normal, pupil moderately dilated, and reaction prompt. The glands in the region of the neck on both sides were about the size of beans, hard, and mobile. The right supra-clavicular glands were the largest, while the left sterno-cleido muscle was hard with infiltration, over which ran a red inflamed line 5 centimetres long and 2 broad, with a granulating ulcer and surrounding ulceration. This was in the region of the beans on both sides, but movable, while those of the axilla were larger, particularly the left side, and as hard as stones. On the other hand, those of the cubitals were not enlarged. The inguinals, however, were large and hard, but could be moved in the direction of the lymph ducts, while those on the inside of the leg and knee were the size of peas.

The spleen was very large, commencing at the normal line above, or ninth rib, and extending far beneath the ribs, and running forwards and internally to within two centimetres of the median line of the body below the level of the umbilicus. The heart was healthy and the lungs perfectly clear on percussion, though a few fine râles could be detected at the apex of the left.

On the first day of treatment the blood was examined, with the following result:—

Hæmoglobin by Fleischl's instrument, 65%
Number of red blood corpuscles, 4,900,000.
Colour index, 0.66.
Number of white blood corpuscles, 24,300.
Small lymphocytes, 19,400 = 79.9 %}
Large lymphocytes, 1,900 = 7.8 %} = 87.7%
Polynuclear leucocytes = 12.8%

After completing this examination, the rays were applied to the left leg on June 13th.

On June 15th the blood was again examined, with the following result:—

Number of white corpuscles, 24,400.
Small lymphocytes, 20,500 = 84.0 %}
Large lymphocytes, 960 = 3.9 %} = 87.9%
Polynuclear leucocytes, 2,930 = 12.0%

On this date the right leg was irradiated. On the 16th both thighs were done, and on the 18th the right arm.

On June 19th the blood was again examined:—

Total white corpuscles, 18,430.
Small lymphocytes, 13,070 = 70.9 %}
Large lymphocytes, 1,130 = 6.1 %} = 77.5%
Polynuclear leucocytes, 4,230 = 22.9%

On this date the right arm was irradiated.

On July 20th blood examined gave:—

White blood corpuscles, 9,860.
Lymphocytes, 7,630.
Small lymphocytes, 6,870 = 69.7 %}
Large lymphocytes, 760 = 7.8 %} = 77.5 %
Polynuclear leucocytes, 2,230 = 22.5%

On this date the right arm was exposed to the rays. The spleen was exposed on the 21st and 22nd, as well as the supra-clavicular glands on the latter rate, while the axillary glands were irradiated on the 23rd on both sides.

On June 25th the blood was again examined:—

Total white corpuscles, 9,130.
Small lymphocytes, 5,730 = 62.7 %}
Large lymphocytes, 800 = 8.7 %} = 71.4%
Polynuclear leucocytes, 2,600 = 28.8 %

The reddening over the left supra-clavicular region is reduced to 3½ centimetres, the infiltration less, and the ulcer healing.

On June 26th the inguinal glands were exposed. On June 27th the blood was examined:—

Total number of white corpuscles, 8,280.
Small lymphocytes, 5,570 = 67.2%}
Large lymphocytes, 880 = 10.6%} = 77.8%
Polynuclear leucocytes, 1,830 = 22.2%

About this period reddening and itching of the skin commenced, and the left hypochondrium was exposed. June 28th a fresh ulcer with infiltration apeared in the supra-clavicular space. June 30th the right hypochondrium was exposed with the anterior side of the liver. On July 2nd the spleen had receded to 5½ centimetres from the median line and ½ centimetre upwards. On July 2nd, 3rd, and 4th the lower bones of the legs were exposed.

July 6th the patient felt very unwell, and complained of sharp pains. The left supra- and infra-clavicular spaces were hard and tender, while the cervical and axillary glands are unchanged. Notwithstanding, both clavicular regions were exposed. On July 12th the left infiltrated supra-clavicular region began to discharge, but the axillary gland remained as before. June 19th the spleen was exposed in front and on the right; on the 20th the left was done, and repeated on the 21st. The ulceration of the infiltrated left supra-clavicular space was found healed on August 3rd. In the neck only a few of the glands could be found on the left side, while the right had a few hard glands about the size of beans. In both axillæ the glands were large.

The spleen from the beginning never exceeded its normal position upwards, but downwards and inwards was enormously increased at first, but was now greatly reduced. It was now a hand's breadth from the median line and four finger breadths below the ribs; the low pole was now on a level with the umbilicus. This viscus was again exposed on the 3rd: (*a*) Front, and (*b*) on the right side. The lower portion of the left leg was irradiated on the 4th, and the blood examined on August 6th:—

White corpuscles, 11,100.
Small leucocytes, 5,170 = 47 %}
Large leucocytes, 1,500 = 13.5%}
Polynuclear leucocytes, 4,430 = 40.3%

August 14th the right leg was irradiated, and on the following day two sittings were given to this limb; on the 16th both arms; on the 17th same limbs were repeated; and on the 18th the spleen was exposed fore and aft.

The patient was now allowed to go home and return in three months' time for further treatment. About the beginning of September, after he went home, he suffered from severe headache which did not keep him from sleeping, and disappeared about the end of the month. Subjectively at this time he felt much better.

On his return, November 13th, he appeared greatly improved, but the face still retained that yellowish-white colour that was present early in the disease, although it had now increased by a reddish infiltration; the pupils reacting promptly, cervical and supra-clavicular glands were less hard and more mobile; one of these lying over the cucularis was very tender. The skin everywhere over the glands was movable, and no ulceration as at the commencement. About the middle of the clavicle in the infra-clavicular space a few of the glands were very painful and swollen about the size of hazel-nuts, while those in the axillæ were the size of walnuts. In the upper third of the arm several were 2 centimetres long, spindle-shape, but not painful. The inguinal glands on both sides were about the size of beans; both lungs and heart were normal. The lower point of the spleen in the axilliary line was slightly below the costal arch and still tender.

On November 13th the examination of the blood gave the folowing:—

Hæmoglobin, Fleischl, 87%
White blood corpuscles, 8,660.
Small lymphocytes, 5,260 = 60.7%
Large lymphocytes, 3.4%
Polynuclear leucocytes, 3,110 = 35.9%
Transformation forms, 0.7%

After this followed another series of irradiations.

On November 14th the right cervical glands were exposed; on the 19th the left infra-clavicular glands were treated; on the 20th and 21st the inguinal glands, both left and right, were exposed. On November 22nd the blood gave:—

Total number of white blood corpuscles, 7,780.
Polynuclear leucocytes, 5,330 = 4.29%

After this examination the spleen was irradiated, and two hours after the sitting the blood examination gave:—

White blood corpuscles, 10,300.
Polynuclear leucocytes, 41%

The patient felt heavy and unwell after this exposure. On November 23rd the total number of

White blood corpuscles were 7,560.
Polynuclear leucocytes, 3,560 = 47%

The spleen was again irradiated for two days, but an unfortunate circumstance called the patient home suddenly, which prevented further treatment.

The diagnosis may now be conclusively stated as a case of benign chronic sublymphæmic lymphomatosis or pseudo-leukæmia, according to Pinkus. The supra-clavicular ulceration must be considered as a secondary infection, which was accompanied with great pain, infiltration, and abscess formation, succeeded by a rapid retrogression.

A NOTE ON

TUBERCULOSIS AS A FACTOR IN THE IRISH DEATH-RATE.

By W. R. MACDERMOTT, M.B.

In 1871, of 1,000 deaths occurring in Ireland, 156 were due to tuberculosis; we would therefore say that the disease as a factor of the mortality had the value 15.6 per cent. Again, taking the average for 35 years, 1871-1905 the same value was 14.9 per cent. But is this a true value—or, in other words, did tuberculosis determine the death-rate year by year? This may be put by asking whether the general rate and the part of it due to tuberculosis varied together, and in what way?

Tuberculosis being a principal cause of death, it might seem *à priori* that in any year a high mortality from it would correspond to a high general rate. There is certainly a relation between the variations of the two rates, but it is not so simple as this; the deviations of both from their means are different, both in magnitude and time. The highest death-rate in the 35 years is 20.0 (1879), the lowest 16.4 (1871); the highest tuberculosis rate is 16.1 (1899), the lowest 13.5 (1879). Contrary, therefore, to what might be expected, the lowest tuberculosis death-rate coincides with the highest general rate. In the ten years, 1871-80, the average G rate, as we will call it for brevity, is 18.3, and the average T rate 14.3; but the maximum T rate, 15.6, coincides with the minimum G rate, 16.4, and this is the rule for the twenty quantities to a significant extent.

In the next ten years the highest G rate, 19.2, coincides with the lowest T rate, 14.3; and the higher T rates, 15.4, 15.6, and 15.2, with the lower G rates. The same rule applies with but few exceptions for the last 15 years, 1891-1905, and to the whole period of 36 years; the G rate for the first ten years being 18.3, the T rate 14.3—they are for the last five years 17.6 and 15.7. The necessary inference to be drawn from the variations in detail is that the general death-rate falls as the part of it due to tuberculosis rises. The thing might be worked out more exactly by Karl Pearson's statistical methods, but anyone who glances at the figures in the last report of the Irish Registrar-General will think the problem itself sufficiently perplexing.

Tuberculosis in some of its manifestations is a very obscure affection, even under the conditions of the more refined means of diagnosis. There is, however, less liability to error where death is assigned to pulmonary phthisis. In the ten years 1871-80 the average yearly number of deaths was 96,674.5, of which 10,352.8 were due to phthisis. For the five years 1901-5 the corresponding numbers were 77,747.4 and 9,511.4. Thus, while the number of deaths declined by about 20 per cent., the number due to phthisis fell by only 8 per cent. Comparing the average for the five years with that for the 35 years 1871-1905, the fall is only 5 per cent. Thus a practically constant death-rate for phthisis has concurred with a fall of 20 per cent. in the total number of deaths. The variation from year to year of the phthisis rate is relatively very small compared with that of the general death-rate, but that of itself shows that the latter is not determined by it in proportion to the relative magnitude of the two rates. No matter whether the total number of deaths is 105,000 or 75,000, the number due to phthisis always remains somewhere about 10,000, and, of course, for this reason appears a minimum when the total is 105,000, and a maximum when it is 75,000. We cannot say that the variation in the total is due to a term falling under the total when that term remains very nearly a constant. Nor is it reasonable to conclude that what remains a constant under a vast variety of circumstances can be changed by means which may affect the true variable.

There are reasons, of course, why the number of deaths from phthisis remains constant relatively to the total as a variable, but it does not appear to me that there is any use at the present time in giving them. The position that the number is a constant is a statement of fact which is worth keeping to; it may be, of course, one applying only to Ireland. In general, however, if 10,000 deaths from phthisis occur, whether the total deaths are 105,000, 95,000, 85,000, or 75,000, it is evident that such number stated as a percentage of the total deaths is misleading. It is even more so stated as a percentage of the living, less the number dying in a year; both the general and phthisis mortality vary according to age distribution independently. I have not studied the remarkable fall which has occurred in the English death-rate from tuberculosis with sufficient care to venture any opinion on its nature and causes worth giving. It seems to me, however, that at no period can the English and Irish rates be compared except subject to corrections difficult or impossible to make. Registration of deaths did not come into operation in Ireland until 1864, and for ten years at least it was imperfect. Both in England and Ireland certification of death by medical men is imperfect, and in many cases impracticable. Judging, however, from intrinsic evidence, I believe the Irish statistics are more reliable than the English; the constancy of the Irish death-rate from phthisis is probably a fair indication of its exactitude.

In the last four decennia the English death-rate has fallen by 15 per cent., but by 33 per cent. for the age period 1-5. As the English population, 32,527,843, was constituted to the extent of 3,716,708 by those in that age-period, this means an accumulation of life in the higher age-periods which by mere increase of mass would give an apparent rise in the mortality occurring in them. But in the four decennia the tuberculosis rate fell by 38 per cent., a percentage not reflected in the general death-rate. The mortality from any cause is, *cæteris paribus*, as the mass it operates on. In England the mortality from phthisis has shifted in a remarkable manner to the higher age periods, and therefore is determined by a rapidly decreasing mass. Thus at 25 the mass would be 2,824,509, and at 45 1,573,188; so that, no other cause intervening, the maximum mortality in rising with age would diminish *pro rata* as the mass affected. In Ireland the age-period 25-35 gives a decided maximum; in England the maxima are given by 35-45 and 45-55, and therefore characterise a relatively much smaller mass. It is probable that, if this were taken into account, what is a constant for Ireland would appear also as a constant for England.

The Irish is predominantly a rural community, the English an urban. Concurring with a reduction of 38 per cent. in the tuberculosis death-rate, the purely rural English population has declined even more than the Irish—that is, the element in which the phthisis mortality is highest has greatly increased; that in which it is lowest decreased. The urban mortality in England is to the rural as the numbers 1,493 and 1,292. We are being told just now, or it is suggested to us, that the decline in the tuberculosis death-rate in England is due to improved sanitation, and, as usual, that country is set to us as an example. I am sufficiently well and long acquainted with it and Ireland to know that, though both are open to improvement in sanitary and other matters, the improvement that has actually occurred in both has been relatively much greater in the latter than in the former country. The assumption that the conditions of life of the rural Irishman are worse than that of the urban Englishman is one which should not be allowed to prejudice the consideration by medical men, at least, of difficult and complicated questions. Tuberculosis as a disease is one thing, as a cause of death another. So is scarlatina. The mortality from scarlatina has fallen in England in the proportion of 890 to 158, but the explanation of that is not that the disease has disappeared or that the infection has been "stamped out"—14,539 cases of it were treated in London hospitals alone in 1901—but that the disease is one thing in itself, another as a cause of death. The increased aggregation of the English people in great cities has favoured experience of the tuberculosis infection, but in all probability careful study and freedom from preconception would show that where tuberculosis, the disease or infection, is a maximum, the mortality from it is a minimum. The mortality is not as the disease, but as the susceptibility to it. In the present state of our knowledge, however, though the grounds for dissenting from the views expounded to uncritical audiences are clear, they do little more than suggest to us that the subject is one not adapted for popular exposition. It is admirable to give popular lectures on hygiene and sanitary science, but the pathology and causation of tuberculosis should be strictly kept as a preserve sacred to the professed votaries of Æsculapius.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Obstetrical and Gynæcological Section.

Meeting held Thursday, December 12th, 1907.

The President, Dr. Herbert Spencer, in the Chair.

THE SUPPORTS OF THE PELVIC VISCERA.

Dr. W. E. Fothergill read a paper on this subject.

The writer considers that the current teaching of gynæcological anatomy, while correct in a general sense, lacks that accuracy which is essential if the student is to have a real grip of his clinical work. It is generally assumed that the urino-genital organs are partly suspended by the so-called ligaments of the uterus, and partly supported from below by the pelvic floor. But the perinæum and the pelvic diaphragm are often seriously impaired by injury or loss of tone, without any consequent change in the position of the pelvic viscera, which shows that support from below is not essential. Again, during abdominal operations the ligaments of the uterus are seen to lie loose and slack upon the subjacent structures, and to have no supporting action whatever. The operation of vaginal hysterectomy affords confirmation of these observations, and reveals to the clinician the fact that the uterus is really supported by the sheaths of its blood-vessels, which attach it firmly to the sides of the pelvic diaphragm. In the same way the vagina and the bladder are held in position by the sheaths of their blood-vessels, the rectum having an independent attachment to the back of the pelvis. Thus lengthening and laxity of the sheaths of the blood-vessels is the one constant and essential factor in the causation of prolapse of the pelvic viscera.

The writer considers that while gynæcologists are well aware of these facts they refrain from teaching them, because they borrow their anatomical statements from the writings of professed anatomists. He therefore goes on to show, by quotation from recent papers by anatomists of the first rank, that descriptive anatomy has changed in a way exactly parallel to that in which clinical gynæcology has moved.

The uterosacral ligament is a mere peritoneal fold; the broad ligament is simply a mesosalpinx and mesovarium. The round ligament is a vestigial structure, the homologue of the gubernaculum testis, which pulls down the ovary and uterus in early fœtal life, and by no means supports them during post-natal life.

The superficial perineal muscles derived from the primitive sphincter cloacæ have a sphincteric and not a supporting action.

The muscles of the pelvic diaphragm are vestigial structures, being the degenerated representatives of the powerful tail-moving muscles of lower vertebrates. Their muscular action is largely lost; but, by virtue of their position, they, with their fascial coverings, form the funnel-shaped musculo-membranous structure known as the pelvic diaphragm. This could not support the plastic pelvic viscera, either by its shape or its muscularity, if the pelvic viscera were not firmly attached to its sides.

The conception of the pelvic fasciæ as independent and definite structures must be given up, and the fasciæ must be regarded simply as the connective tissue-coverings of the muscles, the viscera, and the blood-vessels.

The vessels and their sheaths, together with the ureters, nerves, and lymphatics, form masses of tissue which extend between the sides of the pelvis and the lateral aspects of the uterus, bladder, and vagina, and which hold these structures in position. The rectum is independently attached to the back of the pelvis, and lies loose in a channel between the vessels of the right and left sides. It is free from the urino-genital organs, and does not descend with them in prolapse unless the anterior rectal wall is pathologically adherent to the posterior vaginal wall.

The President (Dr. Herbert Spencer) thanked the author for the interesting and lucid communication he had brought before the Section. Although the question of the support of the pelvic viscera was one to be settled by anatomical research, anyone who had performed total abdominal hysterectomy and had noticed the "ligamentum transversale colli" which lay at a lower level than the uterine artery and was very dense in structure, would find it difficult to accept the statement that it was the sheath of the vessels which kept the uterus in place. Also how could the bladder be kept up by the sheath of the vessels which were small in number and size.

Dr. **Amand Routh** congratulated the author on his lucid and excellent discourse, and felt that it would be greatly to the advantage of both students and gynæcologists if the antiquated views so long held on the subject of the uterine supports were replaced by those now elaborated. He thought that the author had succeeded in proving his contention that the uterus was mainly supported by the perivascular connective tissue bundles above the pelvic floor. He had put into words much of the scepticism which gynæcologists have held as to the acceptance of the orthodox views. No one who is in the habit of opening the abdomen and of seeing the flaccid broad ligaments and the redundant circuitous round ligaments could hold the view that these structures support the uterus, whatever might be thought of the functions of the utero-sacral ligaments. He had long held the view that the connective tissue in the bases of the broad ligament and utero-sacral folds (which really unite and form one common connective tissue bundle at their junction with the supra-vaginal cervix) were very important agents in holding down the uterus to the floor of the pelvis. If in amputating the cervix per vaginam, these bundles are cut through, the freed uterine body can not only be easily drawn downwards by traction, but will be spontaneously elevated behind the pubes, if not held down by vulsella forceps. He thought, therefore, that the bundles of connective tissue grouped round the vessels and the ureters served rather as anchors to fix the uterus down to the pelvic diaphragm, preventing undue mobility both upwards and downwards. The normal anteversion of the uterus is doubtless maintained, according to Dr. Fothergill's views, by the perivascular sheaths suspending the supra-vaginal cervix from a direction upwards and backwards (in the erect position) much in the same way as the utero-sacral folds have been hitherto supposed to act. He hoped Dr. Fothergill's views would receive general attention and acceptance.

Dr. R. H. **Paramore** disagreed with what had been said by the author of the paper. In determining the position of the uterus and the maintenance of this position in the pelvis we had to consider not only the structures which united the uterus to the pelvic wall and the pelvic floor itself, but also the intra-abdominal pressure which had a definite influence upon the position of the pelvic viscera. The intra-abdominal pressure depended upon the capacity of the abdomen, the volume of the abdominal contents, and upon the condition of contraction of the muscles which enclose and form its boundaries. Dr. Matthews Duncan had laid stress on the retentive power of the abdomen, and drawn attention to the fact that the uterus does not alter its position as a result of complete rupture of the perinæum alone, but if prolapse occurred, other factors had come into play. In women with an undamaged pelvic floor, and in whom the intra-abdominal pressure was much increased by a deposit of fat in the omentum or mesentery, the uterus was often found high up owing to the activity of the levator ani. If in such cases the pelvic floor was damaged by child-birth, an inevitable prolapse resulted.

Dr. **Briggs** believed that too much was attributed to ligaments. The muscular and tendinous and other fibrous tissues around a joint controlled its security and mobility, and produced its stiffness. The ligaments of the pelvic viscera were insignificant compared with the mass of the muscles and their fascia, the fibrous packing between, and the fibrous envelopes of the viscera and canals.

Sir **Arthur Macan** said that the importance of the pelvic connective tissue was pointed out years ago by W. A. Freund, and more recently a firm band in the lower part of the broad ligament at each side of the cervix had been differentiated by Kocks under the name "Pars cardinalis lig lati." The effect of taking away the support from below could often be observed clinically in cases where prolapse of the anterior vaginal wall followed rupture of the perinæum. As the vaginal wall prolapsed it drew the cervix downwards and forwards, which produced backward displacement of the fundus, and finally prolapse. Prolapse of the uterus is also met with in old women, due to senile atrophy of the pelvic connective tissue, removing the natural support of the pelvic organs. The strength of the support from below was, he thought, well shown by the resistance the pelvic floor offered to the expulsion of the child's head during labour.

The following specimens were shown:—

Dr. C. **Hubert Roberts**, "A cancerous uterus and glands removed by Wertheim's method."

Dr. **Peter Horrocks**, "Tuberculous disease of the cervix."

Dr. **James Oliver**, "A somewhat unique tubal gestation."

Dr. A. H. N. **Lewers**, "Sarcoma of the ovary complicated by carcinoma of the body of the uterus; operation."

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held December 13th, 1907.

Dr. **George E. Shuttleworth** in the Chair.

Mr. R. **Clement Lucas** opened a discussion on

INHERITED SYPHILIS.

This paper will be published in a future number.

Mr. **Sydney Stephenson's** communication was based upon an analysis of 101 cases of interstitial keratitis. Associated signs of inherited syphilis were present in 69.3 per cent., and of tubercle in 9.9 per cent. of the patients. The series included four examples of keratitis due to acquired syphilis, one of which was in a child, 12 years of age, who had suffered in infancy from a chancre of the eyelid; 61 per cent. of Mr. Stephenson's cases were in females, as against 38 per cent. in males. Four-fifths of the cases occurred between the ages of five and fifteen years, so that interstitial keratitis was essentially a disease of childhood, although cases had been met with at 38 years of age. The symptoms were apt to be atypical when the disease occurred in very young subjects. In one of Mr. Stephenson's patients an interval of seven years had elapsed before the second eye was attacked. Ulceration of the cornea had been noted in four of the author's cases. Stress was laid upon the influence as a determining factor of keratitis of any condition, local or general, capable of lowering the patient's resistance. The name "interstitial keratitis" did not correspond with the pathology of the condition, which was essentially one of inflammation of the ciliary body. An account was given of the experimental production of keratitis, caused in syphilitic cases by the lodgment and multiplication of the treponema pallidum in the tissues of the cornea.

Mr. **George Pernet** said he considered the features of importance in a discussion of this kind at the present moment were heredity and the treponema pallidum. As to heredity proper, we knew little about it. But he desired to emphasise the fact that the usual English designation, congenital syphilis, though not biologically correct, was preferable to the employment of the term hereditary syphilis of Continental writers. All the evidence available pointed to the fact that there was no congenital syphilis of the child without syphilis of the mother. The subject was a complex one to deal with in so short a time, but there were various reasons against the infection of the ovum by means of the spermatozoa, notwithstanding the experiments of Finger with the sperm of syphilitics, experiments which, by-the-bye, had not been confirmed by Erich Hoffmann. Mr. Pernet referred to a case mentioned by Jullien of a syphilitic man with supernumerary fingers who had infected his wife; she had borne a syphilitic child with supernumerary fingers. But the man's mistress gave birth to a perfectly healthy child, also with supernumerary fingers. There could be very little doubt as to the paternity here. It was known, too, that a man with florid syphilis did not necessarily infect his wife. Again, there could be no doubt that Colles's law was a law; the exception to it could not hold water, various conditions, such as pemphigus neonatorum, Jacquet's erytheme erosif, and so forth, having been taken erroneously for syphilis in the child. In conclusion, he desired to insist on the maternal origin of congenital syphilis, and on the reliability of the observations of Abraham Colles and of Baumes.

Dr. H. G. **Adamson** made some remarks on the

DIAGNOSIS OF THE SKIN ERUPTION OF CONGENITAL SYPHILIS.

This was a matter which did not receive the attention which its importance demanded, and errors were often made, especially in regard to certain common non-specific eruptions of the napkin region, which were frequently wrongly diagnosed as congenital syphilis, with obviously serious consequences. The eruptions which might be mistaken for those of syphilis were:—

(1) Streptococcic impetigo.
(2) Seborrhœic dermatitis.
(3) Simple infantile erythema (of Jacquet).

The speaker showed diagrams illustrating the features and distribution of the eruptions in congenital syphilis, and in these three types of simple eruptions.

Streptococcic impetigo produced red, raw areas, with phlyctenular margins in the flexures, or occupying the whole napkin area, with crusted or bullous lesions on other parts.

Seborrhœic dermatitis also attacked the flexures (or the whole napkin region), and the areas had a yellowish red, granular surface. The eruption was associated with seborrhœa capitis in the child and in the mother.

Simple erythema, on the other hand, attacked the prominent convex surfaces of the napkin region, of the calves and of the heels in a marked manner, leaving out the flexures. There were three stages:—

(*a*) Erythematous; (*b*) papulo-erosive; (*c*) ulcerating.

The two latter were especially liable to be confused with syphilitic eruptions, but were distinguished by their affecting only prominent convex surfaces and by absence of other signs of syphilis. The syphilitic eruptions were characterised by disc-like coppery red patches, which might be erythematous, papular, scaly or crusted, and which attacked both flexures and prominent surfaces alike. A special point was that the palms and soles were the seat of these lesions. Other symptoms of syphilis were often present—namely, fissured lips, mucous patches at the anus, snuffles, hoarse cry, and muddy complexion.

Mr. A. H. **Tubby** discussed the

BONE AND JOINT LESIONS IN INHERITED SYPHILIS.

The cranial signs might be localised or general. Local manifestations took the form of bosses which were most marked on the frontal bone. The enlargement of the parietal eminences might exist alone or in conjunction with enlargement of the frontal eminences. Excessive overgrowth of the external occipital protuberance occurred occasionally, but it was a rare condition. The most striking of the lesions in the long bones was that producing syphilitic pseudo-paralysis. It occurred in infants before the fourth month, usually during the second month. The limb became useless, and then a swelling appeared in the neighbourhood of the epiphysis, associated with effusion into the neighbouring joint. Separation of the epiphysis might occur, and pus might form with necrosis of the entire epiphysis.

Dr. **George Carpenter** said that chronic snuffles was not always self-evident, and that it was important to recognise a postrhinal form with discharge by the posterior nares. Craniotabes was, he said, most usual in the second and third months of life, and whenever he detected it, the probability of syphilis occurred to him. Craniotabes was not a rickety manifestation, and Parrot's nodes were evidence of syphilis, not of rickets. He did not believe that syphilis produced rickets. During the first six months the majority of enlarged spleens were syphilitic. From the ninth to the thirtieth month, the rickety age of life, some cases were syphilitic, others could not be explained in that way, and although cases of spleno-megaly did arise in rickety children, they occurred infrequently, and spleno-megaly was a coincidence, not a symptom. Of syphilitic nephritis in infants he gave examples, and pointed out that on several occasions he had been able to diagnose the condition during life. He said that all cases of cirrhotic kidneys were not syphilitic, that in some cases the disease commenced in intra-uterine life, and that the contracted granular kidneys of children and adults could be of either syphilitic or simple, and certainly of infantile origin.

Dr. **Leonard Guthrie** sad that there were two kinds of nephritis attributed to inherited syphilis—acute and chronic. Both were essentially interstitial in character, though in both parenchymatous conditions might be present. Acute interstitial nephritis was sometimes congential, or occurred shortly after birth in undoubtedly syphilitic infants. The symptoms were usually gastro-intestinal at first, and ended in uræmia; œdema was rare in purely interstitial nephritis. The urine was scanty and albuminous, with or without the presence of casts. The kidneys post-mortem showed little that was abnormal to the naked eye, but microscopically interstitial cellular infiltration, formation of new connective tissue, with a varying degree of catarrhal exudation in the tubules. Syphilitic infants might succumb to this within the first few weeks or months of birth. Chronic interstitial nephritis appeared to be the result of the acute form. Clinically and pathologically it was indistinguishable from the chronic interstitial nephritis of adults. Whether the two forms were essentially syphilitic was a matter for discussion. It was certain that in a small proportion of cases congenital syphilis had been recorded, but, on the other hand, no personal or parental history of syphilis was forthcoming in the majority of both acute and chronic cases of interstitial nephritis in infancy and childhood. Dr. Guthrie concluded that a certain proportion of cases might be due to congenital syphilis, whilst others were of septic origin.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, December 5th, 1907.

The President, Mr. **Frank T. Paul**, F.R.C.S., in the Chair.

Amongst a large number of clinical cases shown were the following:—

Dr. T. R. **Bradshaw** showed three patients, adults, suffering from acute anterior poliomyelitis. (1) A man, æt. 53. Sudden onset, hands giving way while patient was sitting on a gate. The paralysis was at first attributed to the fall. Characteristic paralysis, with wasting affecting forearms and thighs. (2) A man, æt. 28. Ill two days with what was supposed to be influenza, and then found to have paralysis of one arm. Condition characteristic. These two cases occurred within a week of one another, and the patients lived in the same district, suggesting an infective source for the disease. (3) Woman, æt. 35. Two years ago sudden paralysis of right leg, slightly of left. At present foot-drop, with coldness and blueness of feet.

Dr. R. J. M. **Buchanan** showed a child who had suffered from tubercular meningitis, and recovered. After an illness of four weeks, and coma for eight days, lumbar puncture was performed, and 20 c.c. of cerebro-spinal fluid removed, containing lymphocytes, but no meningococci were found. The symptoms were classical. An inoculation of 1-4,000 mg. new tuberculin was given. The child showed immediate signs of improvement, and gradually recovered consciousness. Three weeks later the above treatm was repeated, after which the child made an uninterrupted recovery, is now quite intelligent and able to run about. Calmette's tuberculin reaction on the conjunctiva was positive.

Dr. **Buchanan** also showed photographs, and described a case of chloroma in a child of 4½ years. The symptoms commenced with anæmia in July, right facial paralysis with pain in the right ear in October, and exophthalmos followed. The orbital growth is proceeding rapidly. Characteristic blood changes are present, the leucocytosis increasing from 25,000 to 250,000 per c.mm. in a few days.

Dr. J. **Lloyd Roberts** showed:—(1) A case of chancre of the scalp, caused by the patient butting his head in a scuffle against the teeth of a man who had secondary symptoms of syphilis. (2) A case of lead paralysis, which improved rapidly under treatment with iodipin, after potassium iodide had been tried for some time without apparent benefit. (3) A case of transverse myelitis, which improved to a certain extent under potassium iodide and mercury, and was now making more rapid progress with iodipin.

Dr. **Percy Marsh** showed:—(1) A boy, æt. 1 year 9 months, who was admitted into the children's infirmary on November 5th with a history of having had meningitis, with retraction of the head, seven weeks previously. On admission he had marked "intention tremors" of all the parts of the body. The cerebro-spinal fluid was turbid, reduced Fehling, and showed a large number of polymorpho-nuclear leucocytes; a growth of staphylococcus aureus was obtained. There was no optic neuritis, nor atrophy of the disc. (2) A girl, æt. 8, with insular sclerosis. Symptoms were first noticed four years ago after a fall on the head. She now had typical intention tremor, with nystagmus and scanning speech. There was no optic atrophy, and the cerebro-spinal fluid was normal. (3) Two cases of lymphadenoma—(*a*) the ordinary type, with a lymphocytosis varying from 48 to 60 per cent., with a normal blood count; (*b*) sub-lymphatic type. Calmette's ophthalmo-reaction negative. Marked improvement under full doses of arsenic and X-rays.

Mr. R. C. **Dun**:—(1) General thyroid enlargement in a girl 12 years old; tremors and rapid heart's action, but no exophthalmos. (2) Lymphadenoma. (3) Meningocele and accessory auricles. (4) Congenital deformity of hand (two cases), showing syndactylism, microdactylism, and congenital lateral deviation of the fingers. (5) Congenital deformity of lower extremities (two cases). (6) Ischæmic contraction of muscles of forearm following fracture of the humerus.

Dr. H. **Leslie Roberts** showed the following:—(1) Rodent ulcer of nose of two years duration cured by X-rays. (2) Lupoid gummata covering the whole of the front of the neck and a portion of the nose and upper lip. The resemblance to lupus was extraordinary, but the disease was of only one year's duration. (3) Tubercules in a woman, æt. 47, involving the right upper eyelid, the cheek and upper lip, of 3½ years' duration. A sister died of consumption, and the patient had had more than one "hæmorrhage." The lesions were multiple, discrete uniform in their objective characters and their mode of evolution. Each lesion presented the appearance of a slightly elevated convex spot of bluish red colour. At the centre of each spot a slight amount of fluid exudate preceded quiet necrosis, the loss of tissue being followed by a minute depressed scar. (4) Acquired syphilis in a girl, æt. 12. The intoxication rash covered most of the body. The chancre was on the lip, and resembled impetigo. (5) Multiple lupus in a boy, and complicated by secondary inoculations.

Dr. **Stopford Taylor** and Dr. **Mackenna** showed the following cases of skin disease:—(1) Enchondroma cutis in a female child, æt. 15 months. She is the fifth child in a family, all of whom are healthy. In the skin on the outer side of the left thigh, the front of the chest, the back, the left side of the scalp, and the left forearm just above the wrist, are plates of cartilage varying in size from 1¾ in. to the size of a split pea. Over these deposits the skin has a peculiar violaceous hue, and shows here and there a pearly deposit. The cartilaginous nature of the plaques has been confirmed microscopically, and at points the cartilage which is lying in the true skin shows signs of ossification. So far as is known, this is the first case of the kind that has been shown in England. (2) Psorospermosis follicularis vegetans (Darier's disease) in a young woman æt. 32. The disease affects chiefly the neck, the upper part of the chest and back, and the arms. It had lasted for seven years. (3) Ichthyosis nigricans—a very severe case in a boy of 11. (4) Cases of lupus showing Calmette's ophthalmo-reaction. (5) Follicles of the fingers and hands of 13 years' duration in a young woman. The tubercular nature of the disease was confirmed by the presence of tubercular glands in the neck. (6) Case of severe papular syphilis. (7) A Case of hypertrophic lupus of six months' duration (8) A series of 40 wax casts taken from patients suffering from different forms of skin disease.

Mr. J. **Bark** showed cases of the complete mastoid operation, and Heath's conservative method. The patients had been the subjects of fœtid middle ear suppuration of from 3 to 12 years' duration. The results were excellent, and the hearing after Heath's operation was most marked.

Cases were also shown by Dr. N. Raw, Mr. C. T. Holland, Dr. F. H. Barendt, Dr. K. Grossman, Mr. R. J. Hamilton, Mr. A. M. Walker, Mr. T. Guthrie, Dr. McDougall, and Mr. K. W. Monsarrat; an operating table by Dr. Blair Bell; radiographs by Dr. D. Morgan.

WEST LONDON MEDICO - CHIRURGICAL SOCIETY.

Meeting held December 6th, 1907.

The President, Mr. **Richard Lake**, F.R.C.S., in the Chair.

Dr. **Mansell Moullin** read a paper on the

TREATMENT OF UTERINE FIBROIDS,

advocating early operation in all cases giving rise to symptoms. The troubles arising from these tumours were, he remarked, so grave and so varied that, considering the brilliant results now attained by surgery, it seemed worse than folly to allow a woman to spend years of her life as a chronic invalid, exposed to all these risks, when the remedy was at hand—a remedy which might, and often did, become a matter of necessity at a later date. He described the technique of hysterectomy, and advocated the supra-vaginal operation in the very great majority of cases. He had lost but one case in 78 operations. The danger of the operation had been reduced to a minimum, and need not deter one urging radical treatment when called for.

Mr. **Sampson Handley** read a paper on

CHRONIC APPENDICITIS IN WOMEN.

The study of chronic appendicitis had been retarded by two causes—firstly, by the erroneous belief that an appendix free from adhesions is necessarily a healthy appendix; secondly, by the divorce which in England exists between the practice of general surgery and that of gynæcology. The most striking symptoms of chronic appendicitis were located in the female pelvic organs. Of these the most constant and important was dysmenorrhœa. The history of a painful menstrual period precipitated (or brought back after its cessation) by what appeared to be an attack of acute indigestion, was very characteristic of chronic appendicitis. But the main object of his paper was to show that chronic appendicitis in women is frequently accompanied by a definite physical sign. This sign was an enlargement of the right ovary up to double its normal size owing to the congestion and lymphatic stasis produced by the near neighbourhood of an inflammatory focus in the appendix. In such cases the diagnosis of chronic ovaritis was usually made, and futile gynæcological treatment was often carried out for long periods. In one of his own cases appendectomy cured a patient who had submitted without benefit to douching, blisters, tampons, and local applications to the cervical canal, over a period of five years. The appendix was free from adhesions, and its lumen contained a small collection of pus.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY.

Meeting held December 11th, 1907,
at Hanover Square, London.

The President, Dr. W. J. Tyson (Folkestone), in the Chair.

Dr. Edgecombe (Harrogate) read a paper on

BLOOD PRESSURE IN SPA PRACTICE,

the purpose of which was to show the utility of making observations of blood pressure as an aid to diagnosis, and as a guide to hydro-therapeutic treatment. After pointing out that most cases going to spas suffer from chronic diseases of nutrition, in which blood pressure changes afford some indication of the state of tissues nutrition, he discussed the following conditions in relation to blood pressure: arterio-sclerosis, hyperpyesis, gout, fibrositis, heart disease, anæmia, and the menopause, giving cases in illustration of his views. He concluded with a plea for the routine examination of blood pressure in spa practice as affording more precise information than could be obtained by the digital method.

Dr. Leonard Williams, in support of Dr. Edgecombe's views, strongly deprecated the pretensions of those who claimed to be able to estimate the degree of blood pressure by digital examination alone. He recalled Professor Clifford Allbutt's dictum to the effect that it was as absurd to discuss blood pressure in the absence of an instrument as it was futile to discuss temperature in the absence of a thermometer. In further support of Dr. Edgecombe's views he insisted upon the existence of high blood pressure as a functional manifestation which was altogether independent of granular kidney or other structural disease except in so far as its continuance tended to produce these conditions. He discussed the spa and climatic treatment, and concluded that such benefits as were peculiar to this form of treatment resided rather in the greater readiness of patients to obey orders at health resorts than in any properties inherent in the waters, more especially at British spas.

Dr. George Oliver (Harrogate) discussed the blood pressure in gout and the menopause, and gave an outline of his recent observations on the diagnostic value of the armlet method in arterio-sclerosis. He demonstrated his improved hæmomanometer, provided with a supplementary method, which serves as a check against arterio-sclerosis.

Dr. Harry Campbell contended that it was possible to estimate the radial blood-pressure by the finger. He referred to the function of the muscular media in preventing vascular stretching.

The discussion was adjourned to January 29th, 1908.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, Dec. 13th 1907.

At the Verein für Innere Medizin, Hr. Bleichrœder showed a six to seven months' fœtus that had been sent to him for examination. The autopsy showed a diaphragmatic hernia, with sac complete, on the left side, the sac containing all the abdominal viscera. Herniæ of the diaphragm were mostly on the left side in a proportion of 6 to 1. It was a disease of development due to patency of the ductus communis. Below the diaphragm was a horse-shoe kidney with three ureters, one of which was in a state of hydronephrosis.

Hr. Benno Levy remarked that he had shown a similar case some years ago, in which, however, there was almost complete absence of the diaphragm, and the child had been carried to full term. It was not clear to him why the child shown had died so early. The hernia of the diaphragm could scarcely have been the cause of death.

Hr. Klebs showed a guinea-pig that had been infected with

HUMAN TUBERCULOUS SPUTUM

120 days before, and became affected with widespread tuberculosis. He had now brought about its recovery by injections with his own serum. During this process of recovery the tubercle bacilli had been led to the glands, and enormous swelling of the bronchial glands was seen in the preparations. The animal through accident had died.

Hr. Erich Schlesinger spoke on

THE TREATMENT OF NEURALGIAS BY INJECTION.

He recommended the use of isotonic + 0° solutions of salt. Formerly strong narcotic solutions were made use of; then it was found that weak solutions did as well, and now we thought we saw that the chief thing was the mechanical action of the injection, and that the simple isotonic saline solution was sufficient, so long as a larger quantity was injected than formerly. The speaker had obtained brilliant results, especially in the treatment of sciatica, that obstinate complaint. The injection should not be passed into the nerve itself, but into the adjacent tissues.

Hr. Peritz was of opinion that occasional successes had been obtained with all kinds of injection material. It was known that a saline solution was generally sufficient. Alcohol injections were specially recommended for old trigeminus neuralgias. The speaker had laid stress on his success in chronic sciaticas. All cases of so-called chronic sciaticas were myalgias, and not sciatica. How long had he observed his cases? That a saline solution of 0° was given was scarcely possible.

Hr. Remak observed that sciatica cases ran very different courses. Some yielded to any treatment, some to none at all. Salt water injections were harmless, at any rate. That could not be said of other injections, as paralyses were not unfrequently seen to follow injections of alcohol in consequence of parenchymatous neuritis, and just as much as from the injections of ether formerly employed. One could not always avoid injection into the nerve; it got there sometimes without intending it.

Hr. Kraus said that chronic sciatica was known to be the crux medicorum. Whatever treatment was used, complete recovery was rare. It was a great advantage when a method of treatment made patients fit for work. Regarding injections of saline solutions, he could express himself rather more favourably than Peritz. Chronic sciaticas were favourably influenced by it. They had tried everything in his klinik. From his own experience he should recommend blister plasters.

Hr. Rothmann, jun., thought success was obtained by suggestion, and not by injection.

Hr. Alexander said that good results were obtained by saline injections before now. Chronic sciaticas, however, had their seat in the muscles, as the result of acute sciatica. In the latter the muscles were kept in a certain position in which the pain was least felt. This fixed position, by constant tension of the muscles, led to myositis. We therefore found points that were painful on pressure in chronic sciatica that had nothing to do with the nerve trunks, but the terminals of the nerves which were compressed by the muscles. By the injection of larger quantities of fluid the terminals were relieved from pressure, and the cause of the pain removed.

At the Ophthalmological Society, Hr. Adam showed a female with pulsating exopthalmos. Nine years before she had been operated on for an orbital tumour that was either a sarcoma or an enchondroma, and for a year and a half there had been exophthalmos that could be pressed back with some force. There was no arterio-venous aneurysm; it could not be a solid tumour; it could be only a vascular tumour. To determine whether it was arterial or venous, the patient was examined with the head hanging down, and forced to one side, whilst the jugular was compressed. No increase of the exophthalmos took place, so the cause was probably not penous. Considering that it took not a little force to press the eyeball back, it was one with a very free vascular supply, most probably an angio-sarcoma.

AUSTRIA.

Vienna, Dec. 22nd, 1907.

Ischialgia and Infiltration.

At the Gesellschaft, Bum presented six patients whom he had treated with salt injections for chronic ischialgia. All of them had suffered for more than two years with an excruciating pain in the ischial nerve. Bum injected an "isotonic" solution of table salt, under high pressure, with a canula, into the upper part of the thigh. Bum does not insert the canula, as Grossmann, Lange, Kellermann do, into the gluteal muscle, but prefers inserting at the junction of the long head of the biceps femoris and the gluteus maximus, where no wounding of muscles or large vessels can take place. This injection or infiltration of the nerve distends the sheath into a spindle shape, acting mechanically on the neurilemma, and subsequently producing adhesion of the sheath with its surroundings. The action is therefore at first an intense distension, followed by an active contraction of the nerve.

The six patients presented had been free from pain for seven to fourteen months since the operation, although all of them had suffered from pain and been disabled for work for two years preceding the operation, but are now quite fit for duty. He had now similarly operated upon 81 cases, with 63 per cent. perfectly cured, and 21 per cent. greatly relieved. This infiltration treatment is contra-indicated where the cause is neuritis at the root of the nerve, advanced arterio-sclerosis and hysteria. It need not be added that the infiltrating fluid should be perfectly aseptic.

Noorden was quite convinced that Bum's method was the most preferable and free from the dangers that the other methods were subject to, and Laudler was of the same opinion.

Embolism of Pulmonary Artery.

Stoerk exhibited preparations of embolism of the pulmonary artery and branches that had occurred eight days after an operation for umbilical hernia. The ascending aorta and arch were perfectly closed, while the foramen ovale was open. The arteries of the right kidney and the finer branches to the spleen were also closed by emboli. Eiselsberg, who performed the operation, said that the patient was perfectly well on the following day after the hernia was replaced, and no complication threatened. Suddenly, however, on the third day progressive paralysis commenced. Trendelenburg's method of dealing with such cases was immediately discussed, which is that after four or eight hours, when death threatens, the right heart should be opened and the embolus aspirated from the pulmonary artery. Eiselsberg could not decide on this heroic treatment, and the patient died. After examining the heart, it was concluded that the operation would have been of no avail owing to the open foramen ovale.

Bier's Suction Treatment.

Jerusalem pointed out a new indication for Bier's suction treatment in the after-effects of appendicitis. From the beginning he applies Bier's instrument with curved edges for 20 to 30 minutes over the right side of the abdomen. After this is done it is less sensitive and resistant, while the cicatrix becomes soft and the pain much less. The applications vary between 6 and 20. He also finds that Bier's treatment has a beneficial effect on alleviating pain in the abdomen and hastening absorption in perityphlitis, particularly where the infiltration is subcutaneous. He also finds it of much advantage in healing fistulæ, and after laparotomy.

Lead Poisoning.

Teleky briefly related the history of several lead poisoning cases in shoemakers, where the extensor muscles were affected by rubbing a white cream into the leather. Another case was a locksmith with severe encephalopathia saturnia, with extensors also paralysed, the latter being due to the use of a paste. Another was a hatter with thickening of the inner surface of the fingers and thumbs, due to the colophonium or dark resin used in the trade.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

The Late Professor Annandale.—The news of Professor Annandale's tragically sudden death on December 20th was received in Edinburgh with the most profound regret. It is hard to believe that, without any warning, so well-known a figure has been snatched from our midst. Professor Annandale was apparently in his ordinary health on the day before his death. He had performed his ordinary day's work at the Infirmary, and dined at home as usual. The next morning he was found dead in his bed by the servant who went to arouse him. So little was Professor Annandale deemed to be ailing, much less seriously ill, that he was looking forward to being present on the 21st at the prize presentation of the Royal Garrison Artillery, of which regiment his son-in-law, Mr. Norman Mitchell James, is one of the officers. Professor Annandale was a native of Newcastle, but spent the greatest part of his life in Edinburgh. He assisted Professor Lyme, and in 1877 was appointed Regius Professor of Clinical Surgery, and had thus been for thirty years a conspicuous figure in the University and social life of the city. His death was totally unexpected, and the deepest sympathy is felt for his family in their great and unlooked-for bereavement.

The Treatment of Incipient Mental Disease in the Edinburgh Infirmary.—Dr. Clouston has written to the *Scotsman* a second letter advocating this scheme, and giving the results of a postcard plebiscite among the practitioners of Edinburgh. He sent to each of the 379 medical men resident in Edinburgh and Leith the query, "Are you in favour of the establishment of psychiatric wards in the Royal Infirmary for the treatment of early, suitable and transient forms of mental disease?" Two hundred and fifty-eight replies were received; 212, or 82 per cent., answered "Yes"; 26, or 10 per cent., answered "No"; while conditional answers, merely approving the principle, were received from 20. There is thus a very large degree of unanimity in the minds of the profession in favour of Dr. Clouston's proposals. The chief objections put forward are that there are more urgent matters awaiting solution by the managers; that the institution has not the funds to carry out the scheme; that such patients might be a source of danger and annoyance to the other patients; that there is no room within the present Infirmary grounds for such wards; and that there would be legal difficulties and risks. Dr. Clouston's general answer to most of these is, that such wards are successful elsewhere.

Falkirk Fever Hospital.—The Local Government Board inquiry into the charges of maladministration was opened at Falkirk on December 16th. The charges of mismanagement were made by the Rev. N. W. Miskimmin in the course of his campaign in the recent municipal election. The complaints came under four categories:—(1) Irregularities having occurred at the hospital; (2) charge of professional negligence; (3) charge of neglect; (4) a charge of extravagance. Mr. Black, on behalf of the complainers, asked that the inquiry be adjourned in order that they might have adequate time to prepare their case. The object of the inquiry was to restore public confidence, and unless it was thorough and effective that would not be achieved. He suggested that they might lodge a written statement of their case, and the Town Council be asked to answer their charges. Mr Allan, for the Town Council, concurred in the request. Statements had been made against the hospital, and the people had been appealed to not to allow their children or relatives to be taken there. Sheriff Fleming and Sir Henry Littlejohn, who have been appointed to investigate the case, decided, however, to take Mr Miskimmin's evidence before adjourning. The rev. gentleman stated that he had heard complaints, and that these had been substantiated by other persons. The convener of the Public Health Committee used conveyances belonging to the hospital very much longer than was reasonable. There was extravagance in the provision of liquor and foodstuffs, and laxity in ordinary goods. A child of eight had been ill-treated in hospital. According to one order, 72 lbs. of tobacco had been procured, and all this had not been consumed in the hospital, but some had been carried away. Reflections were also made on the quarantine methods during the recent smallpox epidemic, and on the internal administration—card-playing, concerts, organ-playing, late at night. He wanted to see changes both in the convenership of the Public Health Committee and in the Medical Officership. The inquiry was adjourned until January 15th.

The Medical and Dental Defence Union of Scotland.—The fifth annual report records substantial progress in the affairs of the Union. The membership, now 966, has increased by 112 new names during the year. The financial position of the Union is satisfactory. After writing off the last instalment of the preliminary expenses, a balance of £271 has been transferred from the revenue account to the balance-sheet, so that the Union now has £929 9s. to its credit. The Union has done a great deal of useful work in advising and assisting its members, adjusting disputes, obtaining apologies, etc. The annual subscription is only 10s.—a mere trifle, considering the advantages of belonging to the Defence Union.

LETTERS TO THE EDITOR.

THE BRITISH MEDICAL ASSOCIATION.

To the Editor of The Medical Press and Circular.

Sir,—Your editorial references to the British Medical Association are invariably couched in terms of kindness and sympathy, and your note this week forms no exception to the rule. Full of goodwill as we may be to the Association, and alive as we may be to the uselessness, and often the unfairness of mere fault-finding, it is unnecessary to disguise the fact that widespread discontent with the management of the Association exists among large sections of the members. This discontent helps to explain the fact that the membership of the Association numbers less than 20,000 all told—that is about half the numbers eligible in these islands, and within the British Empire. The Association boasts of an enormous income, but of this the greater part is absorbed in the production of the journal, and there are only meagre funds left for activity in other directions. The matter was well put by a correspondent in your pages some time ago. He said the B.M.A. is in reality at present solely a co-operative society for the publication of a journal enormously costly to produce, but certainly supplied to the members at a cheap rate. The journal is too big. In every direction, and, particularly in the editorial department, it could be reduced, and with advantage, to about one quarter of its present bulk. The scientific contributions could also be compressed easily, and to the benefit of the readers, to almost the same extent. The circulation would still command the advertisers, whilst a few thousands a year would be saved for objects now untouched for lack of money. The Association is doing some small thing towards the promotion of scientific research; but if it were able to speak in the name of the majority of the profession, and possessed the organisation necessary to make that voice heard, it might do much more, not only towards the advancement of science, but towards those reforms of so much more vital importance to the bulk of the profession which you, Sir, are so well doing your part to promote.

I am, Sir, yours truly,
Member B.M.A.
December 20th, 1907.

QUACKERY OF QUACKS.

To the Editor of The Medical Press and Circular.

Sir,—I am pleased you have opened your columns for a discussion of the all-absorbing and important question of quackery. I think we might look at our own profession and see if any quackery exists among ourselves. Let me make a few suggestions for your many readers to explore and report their experiences upon. Commencing at the top of the tree, consultants, so-called, in many cases, really self-glorified G.P.'s, Let me ask your readers to record their experiences. Then among the G.P.'s. let me cite one case, and I could cite more. Dr. A. was treating a lady with cardiac dropsy with digitalis. The lady being dissatisfied with her progress called in Dr. B., who remarked to her, no wonder you are not progressing. Dr. A. is treating you quite wrongly. The patient died about a month afterwards, and the family then employed Dr. B. I regard Dr. B. as a quack of the worst order.

Let me glance at the nursing profession. I attended a lady in her confinement, and who employed a trained nurse to nurse her. I ordered an aperient. The nurse remarked *I* always order salts for my patients, you see they act upon the liver. I dealt with this nurse very promptly and effectually. I ask, if a nurse will address a doctor like this, what will her conversation be like, in the absence of the doctor? I shudder to think of it?

I think that many of your readers can give their personal experience upon the subject of midwives. Quackery of the rankest description thrives here. Then we have massage nurses. A patient was suffering from peripheral neuritis, and a nurse was employed to massage the lower extremities. The patient asked me, what is the potential of muscle? The nurse had remarked to her that the potential of her calf muscles was low. I replied, the potential of a muscle is a meaningless term employed by the ignorant to cover their ignorance.

Quackery such as I have mentioned means when referring to the consultant's and G.P.'s. that we have failed to act as gentlemen. When we come to the nursing profession and midwives we must ask ourselves the question, Who is to blame? Surely, ourselves. We have the teaching and examining of them; and we do not sufficiently impress upon them that the superficial knowledge of anatomy, physiology, etc., which they learn, is merely to enable them to take an intelligent interest in their nursing work, and that their duty when nursing a case is faithfully to carry out the instruction of the medical man who is attending, and is alone responsible for the case.

I leave your readers to amplify these remarks. I am sure much practical advantage would accrue from such a discussion.

I am, Sir, your truly,
Bedford, Dec., 18th, 1907. S. J. Ross.

THE BROWN DOG INCIDENT.

To the Editor of The Medical Press and Circular.

Sir,—I had not intended, as I said, to trouble you further, but you have apparently entirely missed my points as to your extraordinary assertion that "animal experimentation had provided the children of Battersea with the only means" of coping efficiently with an attack of diphtheria.

At this moment I am not concerned to either endorse or deny an assertion that diphtheric serum is a very efficient remedy. That is not the point. I again repeat that your assertion is in direct contradiction of established facts on the *ipse dixits* of authorities at least as high as the Editor of The Medical Press, which is no doubt very great. I have read all your articles, and, fortunately, a very great deal besides, or I might take a more narrow and prejudiced view, and fall into the making of so untenable an assertion as the one I have challenged.

I am, Sir, yours truly,
George W. F. Robbins,
Battersea, London, S.W., Secretary.
December 20th, 1907.

[This letter surely requires no comment. We have given Mr. Robbins plenty of room in our columns, and if this letter represents the best he can do, we think it may appropriately wind up the discussion.—Ed. M. P. and C.]

OBITUARY.

REGIUS PROFESSOR OF SURGERY THOMAS ANNANDALE.

The close of the year has been sadly marked and mourned by the profession in Edinburgh, owing to the sudden death of two of its greatest surgeons, the death of Regius Professor Thomas Annandale occurring on Friday last, and that of Sir Patrick Heron Watson on Saturday. Professor Annandale was Surgeon to H.M. the King's Bodyguard for Scotland, Surgeon to the Royal Infirmary, and Consulting Surgeon to the Royal Hospital for Sick Children, Edinburgh. Time precludes us giving more than this brief announcement of the sudden death of these distinguished surgeons. We hope to present a fuller account of their careers in our next.

SIR PATRICK HERON WATSON, M.D., F.R.S., etc.

We regret to announce the sudden death, from heart failure, of Sir Patrick Heron Watson, who died at his residence in Charlotte Square, Edinburgh, on Saturday last.

Sir Patrick, who was born in 1832, was Surgeon-in-Ordinary to the late Queen Victoria, and Surgeon-in-Ordinary to the King in Scotland. He was a past President of the Royal College of Surgeons of Edinburgh, and at the time of his death held the post of Consulting Surgeon to the Royal Infirmary and to Chalmers' Hospital, Edinburgh, receiving the honour of Knighthood in 1903.

JOSEPH LLEWELYN WILLIAMS, M.B., C.M.Ed,, M.R.C.S., J.P.

We regret to record the death, on December 13th, of Dr. J. Ll. Williams, J.P., of Wrexham. He was 63 years of age, and was married to a daughter of the late Mr. Edward Evans. Dr. Williams graduated at Edinburgh, and, after being at St. Bartholomew's Hospital, London, and having obtained the degrees of M.B., C.M., and M.R.C.S., London, he was appointed house surgeon at the Liverpool Northern Hospital. Subsequently he became first Medical Officer of Health for Wrexham, and last year he was appointed Medical Referee under the new Compensation Act. About three weeks ago Dr. Williams was seized with heart trouble, and death was due to cardiac failure. Dr. Williams had an extensive practice in the Wrexham district, and for the past six years had been in partnership with Dr. S. Edwards Jones.

REVIEWS OF BOOKS.

THE PREVENTION OF INFECTIOUS DISEASES (a).

The title of Dr. McVail's last book, "The Prevention of Infectious Diseases," led us rather to expect a work on the subject which broke new and interesting ground, for it cannot be said that much is generally known about the prevention of infectious diseases, at any rate as regards the common infectious diseases of this country. But we find very little in it beyond the usual hardy perennials—isolation, disinfection, vaccination, and so on—and these are merely described as we are accustomed to seeing them described. The reason of the somewhat platitudinous character of the book is that it is a reprint of the Lane Lectures which Dr. McVail gave last year at the Cooper Medical College at San Francisco, and presumably the facts which sound in our ears like a thrice-told tale were to the Pacific audience both novel and interesting. True it is that Dr. McVail has embellished the ordinary run of the narrative with incidents drawn from his own experience, and that here and there we get extracts from reports and registers which do not usually come our way; but, after all said and done, the book is more likely to be of service to the student working for the D.P.H. and to the intelligent layman than to the medical officer of health hungering for fresh tips and pastures new. For instance, in a book of this kind, dealing solely with the prevention of infectious diseases, we should have expected a full and satisfactory statement of the arguments for and against hospital isolation in scarlet fever; but the author, after a few general remarks, dismisses the subject by saying, "I am not going to attempt to argue out this question of hospital influence in scarlet fever." Then, too, with regard to return cases, we hoped to find a full discussion of that lively and disquieting problem, but it receives a bare half-page, and even in that no figures are set out. Now we should have thought questions of this kind deserving of space which is actually occupied with such matter as descriptions of the diphtheria plague, and tubercle bacilli, which are to be found in every text-book; but this brings us back to the point that the work before us is really an elementary one, and that it was brought out for a special purpose and written *ad hoc*. The views are all of an orthodox character, and pleasantly conveyed.

FUNCTIONAL NERVOUS DISORDERS IN CHILDHOOD (a).

Dr. Leonard Guthrie, in the preface to his "Functional Nervous Disorders in Childhood," anticipates that there may be critics and reviewers so churlish as to say, with Merlin—

> "None can read the text, not even I."

Let us hasten to assure him that there is one reviewer at least who not only has read the text but whose pleasure it will be to place it in that select corner of his bookcase over which is written (metaphorically), *Non legendi sed lectitandi*. For this is no ordinary book of scissors, paste, and midnight oil, embellished with extracts from the case-book, and triumphant vindications of the author's theories by reference to success in individual instances which no one else has the opportunity of verifying. It is, on the contrary, an unusually original treatise, dealing with a dark corner in medicine which it illumines with the skill of a sagacious physician, the elegance of a fastidious scholar, and the wit of a consummate man of the world. We do not know whether to praise more the sound learning it reveals, or the brilliance of the style in which it is written; both are admirable. One conclusion that is irresistibly borne in on us is that Dr. Guthrie himself must have been a neurotic child, for not otherwise could he have experienced those poignant sensations which he describes with such fidelity in the first ten chapters, and only personal suffering could have helped him so justly to trounce the unthinking cruelty of pastors and masters towards highly-strung, emotional and shy children. We strongly suspect that some of the excellent stories of childhood's woes, and even shortcomings, are put impersonally on the same principle that the fourth evangelist writes of "the other disciple." But this intense dramatic sympathy with objects of his solicitude does not carry the author into mild and indulgent advice to parents and medical men; on the contrary, nothing could be more measured or more sane than his views of child management generally, and nothing distinguishes him so much as his aversion to faddism and ecstaticism. If the overdoing of good causes could be killed by satire, the thick-and-thin advocates of intemperate "temperance teaching," the total abolitionists of juvenile smoking, the excusers of vice on the "uric acid" hypothesis, and similar excellent and ardent people, would find their activities vastly curtailed. We would that this book might fall into the hands of many of our nascent school hygienists, for they would be bound to recognise that, whilst the author is a master of his subject and an intimate friend of children, he is no partisan of wild experiments of the doctrinaire type which so many enthusiasts are so keen on instituting. Throughout the book, both in the first ten chapters and in the last eleven more strictly clinical ones, Dr. Guthrie shows in a dozen ways his faculty for original observation. In the chapter on "The Fears of Neurotic Children," Dr. Guthrie speaks about gloomy religious teaching:—"Although we may entertain doubts ourselves as to the immortality of moles and pet canaries, there is no occasion to allow our reservations to distress our children." And again:—"The same remark applies to the teaching of all moral, social, and political questions. Exaggerated statements and extreme and biassed views on any topics such as the evils of drink, tea, and tobacco, the land and poor law questions, are in the highest degree injurious to neurotic children." The assertion that smoking in children stunts growth meets with criticism. "It is doubtful whether the most inveterate non-smoker can add an inch, much less a cubit, to his stature," and the sexual purist who has a keen nose for "pollution" is told that "a child who suffers from habit spasm, or happens to be dreamy, shy, and miserable, is not necessarily addicted to secret sins." It is, however, hardly fair to give extracts apart from the "atmosphere" of the book, and that atmosphere we can commend as having tonic qualities seldom found in the literary climatology of medicine.

(a) "The Prevention of Infectious Diseases." By John C. McVail, M.D., County Medical Officer for Stirlingshire and Dumbartonshire. London: Macmillan and Co., Ltd. 1907. 8s. 6d. net.

(a) "Functional Nervous Disorders in Childhood." By Leonard G. Guthrie, M.A., M.D., F.R.C.P., Senior Physician to Paddington Green Children's Hospital. London: Henry Frowde, Oxford University Press. Hodder and Stoughton. 1907.

DIAGNOSIS OF ORGANIC NERVOUS DISEASES. (*a*).

Since the first edition of this well-known book 15 years ago the progress of neurology has, of course, been very great, and Dr. Clark had a heavy task in attempting to bring the book up-to-date. He has performed this in an excellent manner without altering the original form of the book, or disturbing the order of subjects that was so characteristic and practical a feature in the first edition. The eight chapters deal respectively with: The Structure and Functions of the Nervous System, the Symptomatology of Nervous Disorders, the Diagnosis of the Position of the Lesion, the Diagnosis of the Nature of the Lesion, the Diagnosis of Clinical Types, the Distinction of Functional and Organic Disease, the Examination of the Patient, Illustrations of Diagnosis. On the whole the revision is most creditable, and an account is given of the most recent advances, including a short description of lumbar puncture. There are certain exceptions to this, however; for instance, the section on cerebellar localisation is poor, and at least twice as much practical and precise knowledge could have been put in the same space. While, as said, these lapses are exceptional in the main section of the book, the same cannot be said of the chapter (pp. 556-601) on Functional Diseases, which is extremely poor and shows an ignorance of all modern work on the subject. When the first sentence on hysteria contains the statement that the affection consists in a primary derangement of the highest cerebral centres—a statement entirely unfounded on any evidence whatever, and contradicted by all our present knowledge of the subject—we are not surprised to find later on the hackneyed errors dating 30 years back, such as that the face is never involved in hysterial hemiplegia, that there is never ankle clonus on the paralysed side unless there is great contracture, that the onset of the hemiplegia is never accompanied by loss of consciousness, etc.

With the omission of this chapter, however, the book is exceedingly good, and to be warmly recommended as one of the most useful and valuable books on this difficult speciality that we possess at the present day.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Tumour of the Breast.—Mr. James Berry operated on a middle-aged woman, æt. 47, who had noticed for a few weeks a small lump in her left breast. This was as large as a hazel nut, smooth, firm, and evidently in the breast tissue, although quite close to the skin. The latter, however, was in no way adherent to the lump, nor did the nipple show any signs of retraction. No definite enlargement or infiltration of the axillary glands could be felt. With the exception of some heart disease, the patient's health was otherwise good. Mr. Berry pointed out that the diagnosis in such a case lay between an involution cyst and a malignant tumour. The short history, the smoothness and close proximity of the tumour to the skin without involving the latter were all in favour of a cyst. On the other hand, the mere fact that a hard lump existed in the breast of a middle-aged woman was sufficient to raise a strong suspicion of malignancy in the absence of definite signs to the contrary. If there were the least doubt, the proper course to pursue, he said, was to remove such a tumour locally, and then if it proved to be malignant to at once proceed with the larger operation of removal of the whole breast, pectoral muscle, and axillary glands. He thought it better to excise the piece of breast containing the tumour before cutting into the latter, as a better view of the surface of the growth could thereby be obtained. He considered it excessively rare for a surgeon of any experience not to be able to tell at once by naked eye examination of the cut section whether he had to deal with a malignant or an innocent tumour. Occasionally, but very rarely, it happened that under such conditions uncertainty still prevailed, and it might be necessary to have a microscopical section cut on the spot before a definite diagnosis could be made. He strongly deprecated the practice of cutting into a doubtful tumour, and then, if it proved to be malignant, postponing for a few days the performance of the larger operation of removal of the whole breast, etc. Such a proceeding favoured general dissemination, and distinctly lessened the prospect of ultimate cure. The tumour, together with a small portion of the breast, was thereupon removed, and it was found to be a firm, non-encapsuled, solid growth, of the colour and consistency of a raw potato—in other words, a typical scirrhous carcinoma. The larger operation of complete removal of the whole breast, together with the pectoral muscle and axillary glands, was then carried out, special care being taken to remove plenty of the skin because of the close proximity of the tumour to it. It was noticeable that the axillary glands, although not appreciably affected clinically, nevertheless were found to be distinctly affected when the axilla was opened, and some of them on section presented distinct traces of carcinomatous deposit. Mr. Berry said that the great points in regard to naked eye diagnosis of the tumour were: its non-encapsulation and its firmness. Chronic inflammatory lumps in the breast might contain a good deal of fibrous tissue, but they were usually somewhat elastic, and lacked the firm, dense consistency of carcinoma. As the patient had fortunately been operated upon in an early stage of the disease, and the removal had been a very complete one, he thought the prognosis might reasonably be considered a good one. He, like most other surgeons, had many patients on whom he had performed similar operations several years ago, and who had remained quite free from the disease. He also drew attention to the insertion of a large drainage tube at the lower and back part of the axilla. He considered it much safer in cases of cancer to allow the serum and other secretions of the wound to drain away in the first few hours after the operation, rather than to leave them to be absorbed from the wound. The drainage tube should be removed at the latest on the day after the operation.

The patient made a normal recovery, and will be sent back to her doctor in the country in a week after the operation.

"Diagnosis of Organic Nervous Diseases." By Christian Herter, M.D. Revised and enlarged by Pierce Clarke, M.D. Pp. 690. New York and London: Putnam's Sons. 1907. Price 12s. 6d. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Calmette's Ophthalmo-Reaction to Tuberculin.—Boyd (*Scottish Medical and Surgical Journal*, December, 1907) reports a few cases in which he has tried Calmette's ophthalmo-reaction to tuberculin, a diagnostic test to which there have not been as yet many references in English. The test is extremely simple. If a drop of a 1 per cent watery solution of tuberculin is placed in the eye of a tuberculous patient, a definite reaction ensues. Within a few hours there is a congestion of the conjunctiva, which soon passes into definite conjunctivitis. The pupil also becomes dilated. The reaction is at a maximum in 12 hours, and has completely disappeared in a couple of days. The inconvenience to the patient is trifling. No reaction occurs in the eye of a non-tuberculous patient. In the carrying out of the test ordinary tuberculin should not be used, as it is usually suspended in glycerine, which may interfere with the accuracy of the test by irritating the conjunctiva. Calmette advises a preparation of dry tuberculin, which can be dissolved in distilled water before use. He claims that the reaction has a high diagnostic value, and his results have been supported by other observers, including Boyd. If the method should stand the test of time, it will be of great help in diagnosis, as it furnishes an easy method of recognising obscure tuberculous lesions. R.

Fat Embolism.—While fat embolism is only in rare instances a cause of death, it is in itself a frequent occurrence. Graham (*Journal of Medical Research*, July, 1907) publishes the history of a fatal case, and gives a critical summary of the literature of the subject. He concludes: (1) Two lesion complexes may be found in fatal cases of fat embolism. The first consists of an extreme blocking of the pulmonary vessels, together with less marked involvement of those of the heart. There is only a negligible blocking of the vessels of the general circulatory system. The second involves widespread embolism of the vessels, and the pulmonary lesion is overshadowed by lesions of the heart, kidney, and central nervous system. (2) Death occurs in the first class of cases from asphyxia, and follows closely upon the trauma or disease leading to the entrance of fat into the vessels. In the second class of cases it depends upon multiple cerebral emboli, associated with embolism and fatty degeneration of the heart. In such cases death follows only after the lapse of some days. (3) The dividing line between fatal and non-fatal amounts of fat is ill-defined, and individual susceptibility seems to vary. (4) An amount of fat, which would be fatal if suddenly gaining entrance into the blood stream, produces no unfavourable symptoms if it enters the circulation in divided doses separated by intervals of several days. Such fat is gradually eliminated through the kidneys and by the phagocytic action of the leucocytes. (5) Fatty degeneration of the heart in fatal cases is often accompanied by similar changes in the diaphragm, the skeletal muscles remaining unaffected. These diaphragmatic changes may in part account for the respiratory disturbance always observed. R.

Tuberculin Treatment in Children. — Riviere (*British Medical Journal*, October 26, 1907) publishes the results of his experiences of tuberculin treatment in children. As vaccine treatment in general has hardly yet received the support it deserves, we call attention to his paper. Riviere is, on the whole, a disciple of Wright's, and he hardly ventures on any independent criticism. He believes that during treatment the opsonic index should be carefully watched, though he permits treatment without opsonic control where the latter is impracticable. The all-important point as regards success of treatment is dosage, and the discouraging results obtained by some observers have been due to over-dosage. In Riviere's own experience he finds 1-12,000 to 1-8,000 mg. a suitable dose for a child of one year, 1-4,000 mg. for a child of five years, and 1-3,000 for a child of 10 or 12 years. With regard to localised tuberculosis, he finds tuberculin, "in suitable doses, an almost certain remedy." The improvement following on treatment is shown not only by local healing, but by improvement in general health, bodily and mental. Among the cases treated were dactylitis, superficial abscess, tuberculous glands and joints. General tuberculosis should, in Riviere's opinion, also be treated by tuberculin. The opsonic index is thereby steadied, and the general symptoms alleviated. He makes reference specially to phthisis and tuberculous peritonitis. The condition he regards as most unpromising for success is marked wasting. Riviere also believes that the injection of tuberculin in some way gives protection against secondary infections. The opsonic index to other organisms seems to bear a certain parallelism to the tuberculo-opsonic index. Riviere closes with a strong plea for a wider use of tuberculin. R.

The Anæmia of Ankylostomiasis.—Boycott (*British Medical Journal*, November 9th, 1907) describes the points of contrast between the anæmia of ankylostomiasis and idiopathic pernicious anæmia. (1) As regards the histology of the blood-film in pernicious anæmia, many of the cells are large and contain much hæmoglobin, whereas in ankylostomiasis the majority of the cells are small, and contain a small quantity of hæmoglobin. In other words, the colour index of pernicious anæmia is high, that of ankylostomiasis low. Moreover, the more severe the anæmia, the greater the contrast on this point. (2) As regards the volume of blood and its oxygen-bearing capacity, the contrast is equally marked. In ankylostomiasis the volume of blood is nearly twice the normal, and therefore, although the hæmoglobin percentage is only 45 per cent. of the normal, the total oxygen capacity is hardly diminished at all. In pernicious anæmia, on the other hand, there is a real diminution in the total quantity of hæmoglobin in the body, and therefore in the oxygen-bearing capacity of the blood. In severe cases the oxygen-bearing capacity is reduced by a half. R.

Pelvic Inflammation in the Female.—Wilson (*Journal of Obstetrics and Gynæcology*, July, 1907), in the course of a general paper on pelvis inflammation, gives some bacteriological findings of interest. In the case of twelve recent puerperal infections, micro-organisms were found in every case, the distributions being as follows:—Streptococci alone, 4; streptococci with staphylococcus aureus, 2; streptococcus with other organisms, 4; other organisms, 2. It is not so stated, but we gather that the cases referred to were examined on the post-mortem or operation table, and were therefore cases of great severity; hence the high proportion of streptococcal infections. In 43 cases of sub-acute or chronic suppurative pelvic inflammation, no germs were found in 10 cases; in 10 streptococcus was found alone; and in association with other germs in 5; staphylococcus aureus was found in 2; staphylococcus albus in 1; and mixed staphylococci and pneumococci in 1; bacillus coli was found in 1. With regard to pyosalpinx, of 13 cases examined, 4 were found to be sterile; 1 contained streptococcus, 1 staphylococcus albus; 1 staphylococcus and pneumococcus; 1 gonococcus; and 5 various saprophytes. R.

The Cancer Problem.—Skerrett (*British Medical Journal*, November 2nd, 1907) makes an ingenious suggestion bearing on the nature and treatment of cancer.

Starting with the facts that the essential characteristic of the cancer cell is its apparently unlimited power of reproduction, and that reproduction is governed by the cell-nucleus, he asks whether it is possible so to act on the nucleus as to inhibit this power of excessive reproduction. He then refers to the observation that acute inflammations seem to exert a retrogressive influence on cancerous growths. He suggests that it is possible that the pabulum for the excessive nuclear growth in cancer is supplied by an influx of leucocytes to the part, and that the effect of inflammation is to starve the tumour by depriving it of its leucocytic supply. Would it then be possible, he asks, to modify nuclear growth by diminishing in the food the supply of the materials necessary for the formation of nuclein—or so to act on nuclein as to alter its functional activity? In reply to the latter question he suggests the possibility of supplying arsenic with the food, so that the nuclein molecule might possibly take up that metal instead of phosphorus, and thereby undergo some change in its functional activity. He suggests, therefore, that the results of taking a nuclein-free diet while arsenic is administered internally should be observed. R.

MEDICAL NEWS IN BRIEF.

Contamination of Town Milk.

Dr. G. Trew Cattell, one of the medical officers of health for Berkshire, has just issued a report dealing with his inspection this year of the dairies and milkshops. In taking samples of milk fresh from the cow, and kept in a covered vessel for a certain period of time, and also taking samples which had been exposed in large open porcelain bowls for a like period to the ordinary conditions prevailing in the main street of a town, he found the number of micro-organisms from the one so exposed to be enormously increased as compared with the covered sample. The dust of the streets of a town was mixed largely with the dried excreta of animals and human expectoration, and very frequently contained germs of disease. The bacilli of scarlet fever, of tuberculosis, and of enteric fever specially throve in milk. It was quite possible that many epidemics of the former disease which had begun in a mysterious manner and whose cause had never been accurately determined, might be traced to the accidental contamination of the milk supply in the manner indicated. The habit which consumptive people had of constantly expectorating—a habit which, from the nature of their disease, it was difficult to prevent—constituted a serious danger. The sputum, generally swarming with tuberculous bacilli, quickly became dried on the pavement or roadway, and was blown about in the form of dust, and, should this settle on the milk, there was a grave possibility of children being brought into contact with tuberculous infection, to which they were peculiarly susceptible. He suggested that greater care was necessary in the way that milk was handled before sale, and that it should never be allowed to be exposed in uncovered vessels. It would, he added, be an advantage if all authorities in the county adopted one set of regulations, thus securing unanimity of action.

Teaching of Midwifery in Ireland.

A meeting of Masters, Assistant Masters, and ex-Assistant Masters of the Dublin Maternity Hospitals was held in the Royal College of Physicians, Dr. Hastings Tweedy, Master of the Rotunda Hospital, in the chair. The following resolution was proposed by Dr. R. D. Purefoy, ex-Master of the Rotunda Hospital, and seconded by Dr. Gibson, Master of the Coombe Hospital, and passed unanimously:—'That this meeting, consisting of the Masters and Assistants, past and present, of the Dublin Maternity Hospitals, is unanimously of opinion that the proposed shortening of the course in practical obstetrics from six to three months would seriously interfere with the work of the maternity hospitals; that it would increase, rather than lessen, the difficulties in providing each student with the required number of cases; and that, at the same time, it would materially diminsh his opportunities of obtaining practical instruction." It was then proposed by Sir William Smyly, ex-Master of the Rotunda Hospital, seconded by Dr. A. J. Horne, Master of the National Lying-In Hospital, and passed unanimously:—"That, in the opinion of this meeting, it is most desirable that the recommendations of the General Medical Council with regard to a Clinical and Practical Examination in Obstetrics and Gynæcology, be adopted, especially as the meeting has been assured that the Masters of the Maternity Hospitals will further the scheme by every means in their power."

Infantile Mortality in Poplar.

In reporting upon the desirability of appointing a female health visitor in Poplar, the Public Health Committee of the Poplar Borough Council state that last year in the borough 822 infants under one year of age died, and of these 188 were under one month old. The total number of births in the year was 5,363. Upon inquiries at 26 factories in Poplar, where a total of 5,641 women are employed, it was found that 769 were married, or 13.6 per cent. The Local Government Board have asked the Poplar Council what action they propose to take upon the information of births to be received under the Notification of Births Act with a view to the reduction of infant mortality. The Public Health Committee will recommend the Council to agree to the principle of the appointment of a health visitor.

The Coombe Hospital, Dublin.

A special meeting of the directors of the hospital was held on December 17th to elect a Master in place of Dr. Thomas G. Stevens, whose period of office had expired. There was a large attendance of Governors, the Right Hon. the Lord Mayor presiding. The candidates were: Dr. M. J. Gibson, M.A., M.D., B.Ch., B.A.O., Dub. Univ., and Dr. Thomas Neill, B.A., M.B., B.Ch., B.A.O., Dub. Univ., both having occupied the position of Assistant Master in the hospital. A ballot having been taken, the Lord Mayor declared Dr. Gibson elected by 11 votes as against 5 for Dr. Neill. The newly-elected Master was then notified by the Chairman of his election to the responsible position, and Dr. Gibson having thanked the Board for the confidence they had placed in him, the proceedings concluded.

PASS LISTS.

Royal College of Surgeons, Edinburgh.

At a meeting of the College held on the 16th inst., the following gentlemen were elected Fellows:—Bryan Foster, M.B., Ch.B., Melb.; William James France, L.R.C.S.E.; Henry Goodwyn, L.R.C.S.E.; Henry John Lotz, M.R.C.S.Eng., L.R.C.P.Lond., D.P.H. Camb.; Raymond Herbert Price, M.B., C.M.Edin.; John Fordyce Robertson, M.D.Edin.; Cyril Shellshear, M.B., C.M.Syd.; Fred Stoker, M.B., Ch.B.Durh.; Herbert Pank Thompson, M.D.Edin.; Walter Woodword White, M.D.; C. M. McGill, L.R.C.S.E.; David Percival Dalbreck Wilkie, M.B., Ch.B.Edin.; and James Wilson, M.B., Ch.B.Aberd.

Apothecaries' Hall, London

The Society of the Apothecaries of London has granted the L.S.A. Diploma to the following candidates, entitling them to practise Medicine, Surgery, and Midwifery:—R. Beesley and E. S. Cooke.

The Salford Board of Guardians recently decided that public vaccinators should receive half-a-crown for each case of successful primary vaccination and re-vaccination performed by them at the surgery, and that the fee for each case after the twenty-ninth should be one-and-sixpence.

The *Daily Mail Year Book* having now attained the eighth year of its existence, has become more or less familiar to readers. It contains the usual vast storehouse of information of a manifold kind. One interesting feature is the brief biographies of men and women of our time. The price of this 1908 compendium of reference for the writing desk is only sixpence.

NOTICES TO CORRESPONDENTS, &c.

☛ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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EASTERN.—The Siamese certainly are going ahead, and have a good appreciation of European medicine. As the result of a visit recently paid by the King of Siam to the Virchow Hospital in Berlin, a contract has been placed for the whole equipment of a similar hospital for the city of Bangkok. The building materials are to a large extent to be shipped from Germany, and there will be an installation of apparatus, not only for carrying out operations in major surgery, but also for bacteriological work. An ambulance department has already been inaugurated in the Siamese defensive services, the Geneva Red Cross being adopted with a vernacular emblem, and the King of Siam is desirous of conferring upon his subjects the full advantages of modern progress. The sum to be expended, including buildings and the expenses of the staff, cannot be less than £25,000.

THE INDEX FOR 1907.

The Index for the present volume, of which this number is the last, will appear in our next week's issue.

MR. J. WATSON.—The question of priority in the discovery of the infection of Malta Fever is fully discussed in our issue for November 6th, 1907, page 510.

THE NEW TREATMENT.

Away with judge and jury, pray!
For court and gaol have had their day,
  No more shall laws control us;
We shall, immune, from every ill,
Cure murderers by a little pill
  And burglars by a bolus.

If draughts, not of the sort he likes,
Effect no cure in Mr. Sikes,
  Then careless what 'twill cost us,
Our stern prescription, I profess,
Shall, while we look for swift success,
  Be "Repetatur haustus!"

If he, however, grow and grow
In crime and vicious habits, though
  To virtue we still urge on,
Aware what treatment best befits
His fell disease, we'll call for its
  Removal by the surgeon.

Our grateful praise then, I insist,
Is what the skilled pathlologist
Shall—what reward's like that?—earn,
  For soon "the mixture as before"
Shall make our gaol-birds more and more
  To all mankind a pattern.

M. S.

—*Daily Chronicle.*

WESTRALIAN.—There are several Post-Graduate centres in London, offering various facilities for study. Apply to the Dean of the West London Post-Graduate College, Hammersmith Road, W., or to the North-East London Post-Graduate College, Prince of Wales's Hospital.

SUBSCRIBER, M.D.—We have carefully considered the matter and laid the facts—impersonally, of course—before a member of the profession, who is well acquainted with such problems. His advice, in which we concur, is that you would do well not to accept such an appointment under present circumstances. The advantages that might accrue would be more than counterbalanced by the risks involved.

Appointments.

DEVANE, J. F., M.B., B.Ch., D.P.H., House Surgeon at the County Infirmary, Limerick.

GUNNING, C. J. H., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Ophthalmic Department at St. George's Hospital.

HAWTHORNE, C. O., M.D.Glasg., M.R.C.P.Lond., Examiner in Medicine and Clinical Medicine in the University of Glasgow.

MORRISON, J. T. J., M.B.Cantab., F.R.C.S.Eng., Examiner in Medical Jurisprudence at the University of Glasgow.

NICOL, J. H., M.B., M.S.Glasg., Examiner in Surgery at the University of Glasgow.

ROBB, D. M., M.B., Ch.B.Edin., Senior House Surgeon at the Clayton Hospital, Wakefield.

SLOAN, SAMUEL, M.D., M.S.Glasg., Examiner in Midwifery at the University of Glasgow.

Vacancies.

St. George's Union.—Second Assistant Medical Officer at their Infirmary, Fulham Road, West Brompton, S.W. Salary, £120 per annum, with board, residence, and washing. Applications to the Medical Superintendent.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—A Casualty Medical Officer. Salary, £200 per annum, with lunch. Applications to Stewart Jones, Secretary. (See Advert.)

Parish of Bermondsey Infirmary.—First Assistant Medical Officer. Salary, £170 per annum, with rations, washing, furnished apartments, and attendance. Applications to E. Pitts Fenton, Clerk, 283, Tooley Street, S.E.

University of Sheffield.—Demonstrator in Anatomy. Salary, £150 per annum. Applications to W. M. Gibbons, Registrar.

Birmingham City Asylum.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Huddersfield Infirmary.—Male House Surgeon. Salary, £100 per annum, with board, residence, and washing. Applications to Mr. J. Bate, Secretary, Infirmary, Sheffield.

West Riding Asylum, Wadsley, near Sheffield.—Fifth Assistant Medical Officer. Salary, £140 per annum, with board, etc. Applications to the Medical Superintendent.

General Hospital, Barbados.—Junior Resident Surgeon. Salary, £200 a year, with separate furnished quarters. First-class passage out provided. Applications to Sir Frederick Treves, Bart., care of the Warden, London Hospital Medical College, Mile End, E.

The Middlesex Hospital, W.—Resident Medical Officer. Salary, £200 per annum, with residence and board. Applications to F. Clare Melhado, Secretary-Supt.

Cardiff Union.—Assistant Medical Officer. Salary, £130 per annum, with rations, apartments, attendance, and washing. Applications to Arthur J. Harris, Clerk, Union Offices, Queen's Chambers, Cardiff.

Kent County Asylum, Maidstone.—Fourth Assistant Medical Officer. Salary, £175 per annum, with furnished quarters, attendance, coals, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

Births.

ARGLES.—On Dec. 17th, at Multan, Punjaub, India, the wife of Captain R. L. Argles, R.A.M.C., of a son. (By cable.)

WARD.—On Dec. 13th, at Wellwood, Bloemfontein, O.R.C., the wife of Arthur Blackwood Ward, M.B., of a son.

Marriages.

DE SELINCOURT—WHEELER.—On Dec. 19th, at Lyndhurst Road Congregational Chapel, Hugh, youngest son of Mrs. de Selincourt, of 26, Belsize Grove, London, to Janet, youngest daughter of Henry Wheeler, L.R.C.P.Lond., M.R.C.S.Eng., of Norwich.

EMBLETON—BOYD.—On Dec. 20th, at St. John's, Hampstead, Dennis, eldest son of the late Dennis C. Embleton, M.D., M.R.C.S., L.R.C.P., of Bournemouth, and grandson of the late Dennis Embleton, M.D., F.R.C.S., F.R.C.P., of Newcastle, to Alys Faraday, daughter of Philip Boyd.

BARDSWELL—MACK.—On Dec. 14th, at St. Margaret's Church, Paston, Norfolk, Noel Dean Bardswell, M.D., son of the late Charles William Bardswell, Recorder of Kingston-upon-Thames, to Monica, elder daughter of John Mack late XX. Regiment, of Paston Hall, Norfolk.

BOYAN—CATTY.—On Dec. 18th, at the Church of St. Joseph, Newbury, Staff-Surgeon John Boyan, Royal Navy, eldest son of Mr. Thomas Boyan, of Rathmines, Dublin, to Pearl Alexina Macdonald, younger daughter of the late Major-General Charles Parker Catty, 46th Regiment.

MARSDEN—HANNAH.—On Dec. 18th, at St. Thomas's Church, Ashton-in-Makerfield, Prosper Henry Marsden, Lecturer in Pharmacy in the University of Liverpool, to Jessie, third daughter of Dr. Hannah, M.O.H., Ashton-in-Makerfield.

HAVILAND—HUXLEY.—On Dec. 20th, at the Registrar's, Kensington, Heath John Haviland, son of the late Captain R. H. Haviland, of Bath, to Ellen, daughter of the late James Edmund Huxley, M.D., of Maidstone, Kent.

HEMSTED—CASH.—On Dec. 18th, at The Friends' Meeting House, Torquay, John Garnet Hemsted, L.D.S., M.R.C.S.Eng., of Torquay, youngest son of Dr. Hemsted, of Whitchurch, Hants, to Violet Mary, second daughter of Dr. A. Midgley Cash, of Limefield, Torquay.

Deaths

COMERFORD.—On Dec. 2nd, at St. Vincent's, Ventnor, I.O.W., Deputy-Inspector-General J. T. Comerford, M.D., R.N. (retired), aged 64.

DUKE.—On Dec. 12th, at 44, Northumberland Avenue, Kingstown, Caroline Georgina, widow of the late Fleet-Surgeon Valentine Duke, R.N.

MAITLAND.—On Dec. 20th, at his residence, Langdon, Bournemouth, Lt.-Col. John Maitland, M.D., I.M.S. (retired), of Madras, aged 55.

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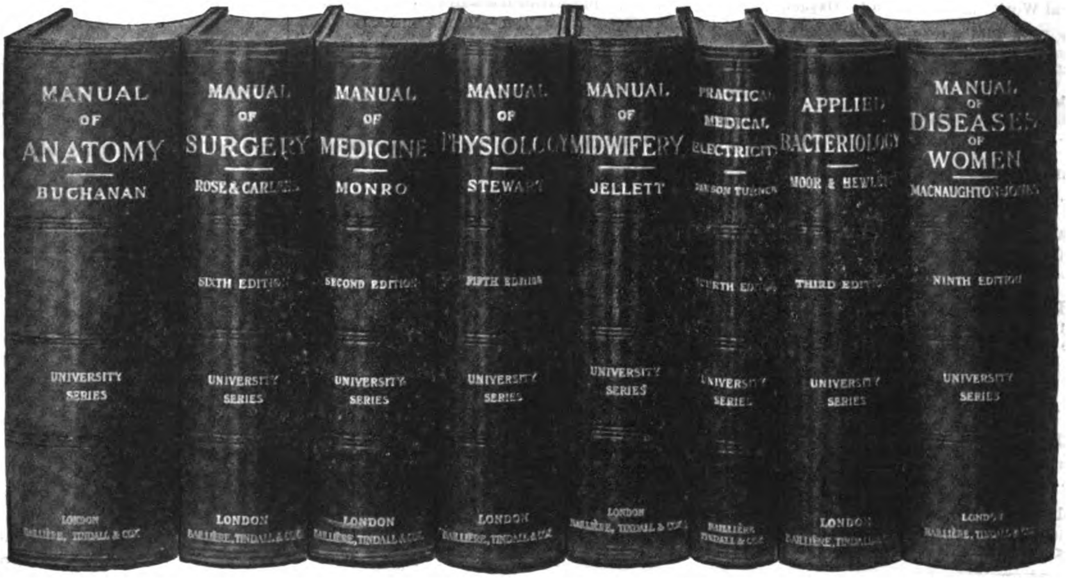
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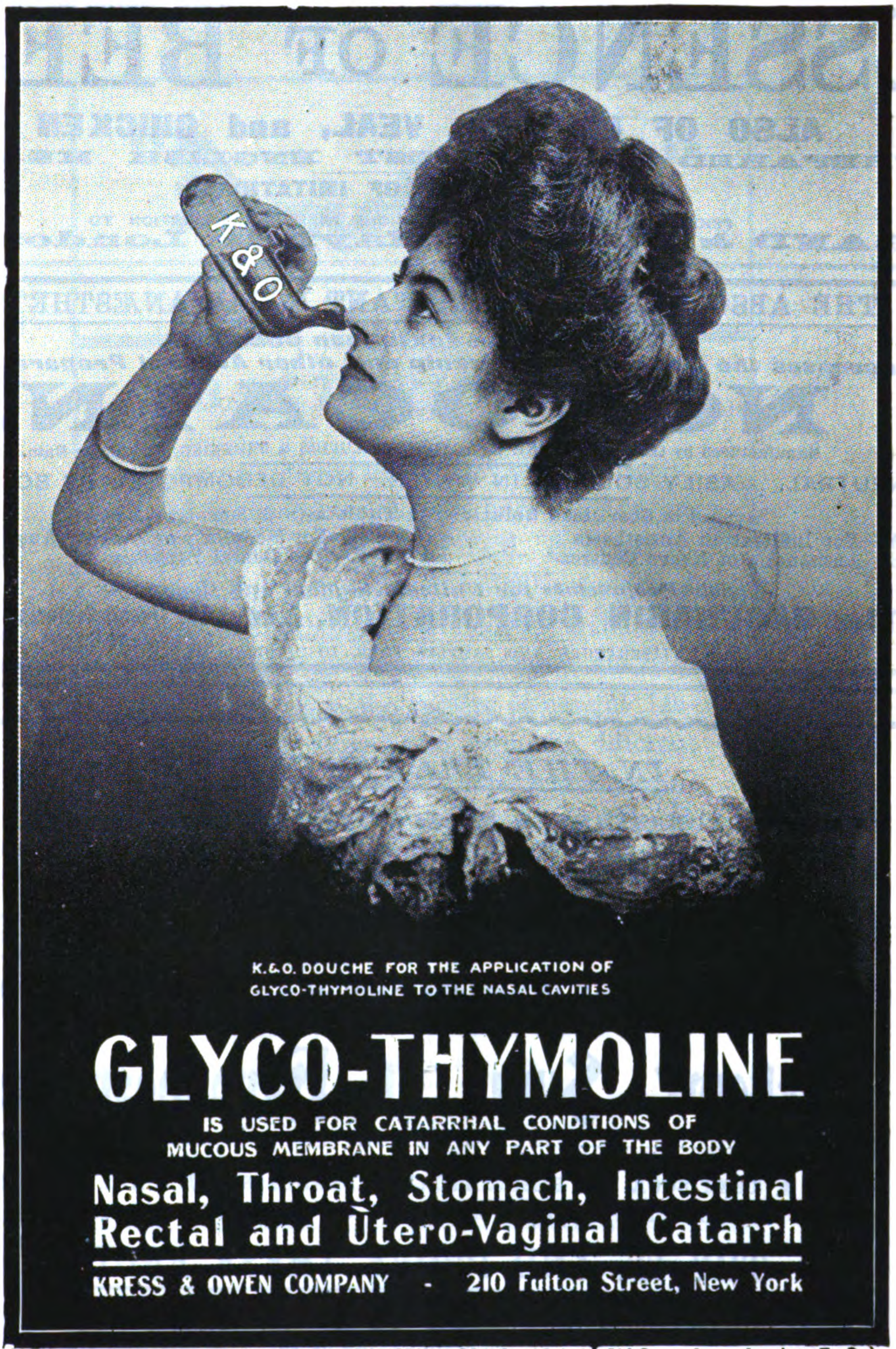

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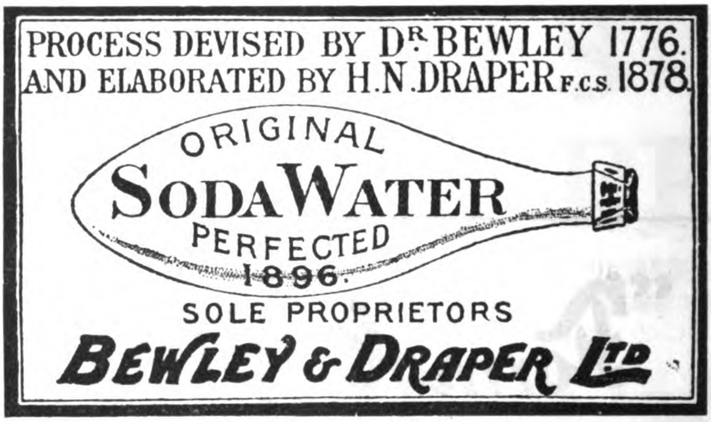
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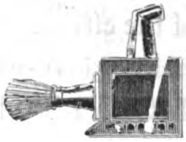

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Carbonate of Iron	0·097
Carbonate of Manganese	0·429
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By Order of the Committee of Management,

11th December, 1907. STEWART JOHNSON, Secretary.

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Secretary.

20th December, 1907.

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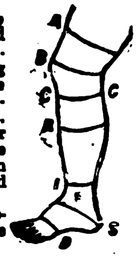

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